ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC031820
Case Name	RODRIGUEZ, JUAN v. PROVEN PARTNERS
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0171
Number of Pages of Decision	24
Decision Issued By	Christopher A. Harris, Commissioner

Petitioner Attorney	John Castaneda
Respondent Attorney	James Zahour

DATE FILED: 4/21/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUAN RODRIGUEZ,

Petitioner,

vs. NO: 16 WC 31820

PROVEN PARTNERS MANUFACTURING, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Petitioner herein with notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission 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 has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. While the Commission agrees, in part, with the weight assigned by the Arbitrator to the five factors under Section 8.1b of the Act, the Commission finds that the PPD award was insufficient to compensate Petitioner for his work-related left foot injury. The Commission further seeks to modify the weight given to the third factor [the age of the employee].

Petitioner was 46 years old when he sustained a work-related injury to his left foot on August 13, 2016. Petitioner was a maintenance worker whose job duties required him to stand or

be on his feet throughout his shift. The Commission agrees with the Arbitrator's conclusion that Petitioner must live and work with his disability for a number of years and finds this a significant factor to consider. Accordingly, the Commission modifies upwards the weight placed on this third factor.

After reviewing the factors in their totality, with no single enumerated factor being the sole determinant of disability, the Commission finds that twenty-seven-and-a half-percent (27.5%) loss of use of the left foot corresponds more appropriately with the evidence in the record and the injuries sustained by Petitioner as a result of the August 13, 2016 work accident. The Commission therefore modifies the PPD award from twenty-percent (20%) loss of use of the left foot to 27.5% loss of use of the left foot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed April 23, 2020, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services related to Petitioner's left foot, and received prior to July 26, 2018, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical care is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for temporary total disability benefits from December 30, 2018 through January 31, 2020 is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request that penalties and attorney's fees be imposed upon Respondent is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability (PPD) benefits of $286.00 per week for 45.925 weeks, because the injuries sustained caused the twenty-seven-and-a-half-percent (27.5%) loss of use of the left foot, as provided in Section 8(e) of the Act. Respondent is entitled to a credit of $1,084.33 for a PPD advance previously paid to Petitioner.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,200.00. 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 the Circuit Court.

4/21/2021

/s/ *Christopher A. Harris*

CAH/pm
O: 4/15/21
052

/s/ *Barbara N. Flores*

/s/ *Marc Parker*

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

RODRIGUEZ, JUAN Case# **16WC031820**
Employee/Petitioner

PROVEN PARTNERS MANUFACTURING LLC
Employer/Respondent

On 4/23/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% 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:

5317 CASTANEDA LAW OFFICE
JOHN J CASTANEDA
514 W STATE ST SUITE 210
GENEVA, IL 60134

5033 LAW OFFICE OF FRANK S CAPUANI
EDWARD JANUSZKIEWICZ
135 S LASALLE ST SUITE 2950
CHICAGO, IL 60603

21IWCC0171

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Juan Rodriguez
Employee/Petitioner

Case # 16 WC 031820

v.

Consolidated cases: ____________

Proven Partners Manufacturing LLC
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 Frank Soto, Arbitrator of the Commission, in the city of WHEATON, on January 31, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [x] Other MMI or prospective medical care

FINDINGS

On the date of accident, August 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $22,508.72; the average weekly wage was $432.86.

On the date of accident, Petitioner was 46 years of age, married with 1 dependent children.

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $1,034.33 for other benefits, for a total credit of $1034.33 for PPD advance payment.

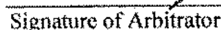
Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Medical benefits: Respondent shall pay Petitioner for the medical treatment received prior to July 26, 2018 as identified in Petitioner's exhibits 1-9, pursuant to Sections 8(a) and 8.2 of the Act and subject to the Illinois Medical Fee Schedule, as contained in the Conclusions of Law attached hereto;
Prospective Medical Care: Petitioner failed to prove by the preponderance of the evidence that he is entitled to prospective medical care, as contained in the Conclusions of Law attached hereto;
Temporary Total Disability: Petitioner failed to prove by the preponderance of the evidence that he was entitled to temporary total disability benefits, as contained in the Conclusions of Law attached hereto;
Penalties: Penalties are denied.
PPD: The Arbitrator finds Petitioner permanently and partially disabled to the extent of 20% loss of use of the left foot under Section 8(e), which amounts to 33.4 weeks benefits less the sum of $1,084.33 for a PPD advanced previously paid by Respondent, as set forth in the Conclusions of Law attached hereto;

Respondent shall pay Petitioner compensation that has accrued from August 13, 2016 through January 31, 2020 and shall pay the remainder of the award, if any, in weekly payments

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.



Signature of Arbitrator

4/17/20
Date

APR 2 3 2020

Procedural History

This matter was tried on January 31, 2020 pursuant to Sections 19(b) and 8(a) of the Act. The disputed issues involve the following: Whether an accident occurred that arose out of and in the course of petitioner's employment; Whether Petitioner's current condition of ill-being is causally related to his accidental injury; Whether the medical services provided to the Petitioner were reasonable and necessary; Whether Petitioner is entitled to any prospective medical care; What amount, if any, of Temporary Total Disability is due to Petitioner; and Whether penalties and fees should be imposed upon Respondent. The Parties stipulate that if the Arbitrator determines Petitioner reached MMI, the nature and extent of Petitioner's permanency should be addressed. (Arb. Ex. #1).

Findings of Fact

Juan Rodriguez (hereafter referred to as a "Petitioner" testified he worked in maintenance for Proven Partners manufacturing (hereinafter referred to as "Respondent") and his duties included sweeping, Mopping and packing boxes. (T 9-10). Petitioner had to lift boxes with product weighing twenty-five to fifty pounds. (T 10). Petitioner's regular shift was from 6:00 a.m. and ended at 4:30 p.m. (T 12). Petitioner testified that Saturday, August 13, 2016, a forklift driver passed by and left a pallet in the way. Petitioner testified he told the forklift driver to move the pallet and the forklift driver put the forklift in reverse, turned the wheel too much, and ran over his left foot. (T 12-13). Petitioner testified the accident happened around 2:30 or 3:00 p.m. and a half hour left in the day, so he kept working went home and placed a bag of ice on his foot. (T 12-13). Petitioner testified he kept ice on his foot the following day (Sunday) and returned to work on Monday. (T 14). Petitioner testified worked until his first break and, at that time, he demanded someone from the office take him to the doctor. (T 14). Petitioner testified that he was taken to Physicians Immediate Care. (T 15)

On August 15, 2016 Petitioner presented at Physicians Immediate Care reporting left foot pain after a forklift ran over his foot. The medical records state, "*. . . patient presents with a chief complaint of constant (but worse at times) pain of the left foot since Sat. August 13, 2016 at 3:00 p.m. . . . patient reports it was the result of an injury that occurred on 8/13/2016, which was work related. . . a forklift ran over the top of his left foot at work, feels better today but still painful.* ". The examination of the left foot noted tenderness over the ankle, tenderness anteriorly, tenderness over foot, tenderness proximally, tenderness laterally and over the plantar.

The exam also noted the following: No atrophy or deformity of the ankle, foot, and toes; No swelling or mass of the ankle, foot or toes, No skin with ecchymosis; No lesion of the ankle or foot; No wound of the ankle or foot; Normal range of motion; No ankle weakness; Negative inversion stress test; Negative eversion stress test and negative anterior drawer test. Three x-rays were taken showing no dislocation, no soft tissue swelling, no calcification, no foreign bodies and the joint spaces were well maintained. Petitioner was diagnosed with a left foot contusion. Petitioner was prescribed Provil and non-aspirin extra strength and was released to return to work full duty. (Px. 1).

On August 20, 2016, Petitioner returned to Physicians Immediate Care reporting was feeling 20% better but still had pain on the top and bottom of his foot which occasionally radiated up his leg. The exam noted no ankle swelling, no malleolus swelling, proximal foot without swelling, distal foot without swelling, lateral foot without swelling, medial foot without swelling, heel without swelling, arch and ball of foot without swelling and no swelling of the toes. The exam also noted no edema, no atrophy, no ecchymosis, no lesion normal range of motion and normal testing. The exam identified some dorsal foot swelling and plantar foot swelling. Petitioner was diagnosed with a left foot contusion, prescribed non-aspirin extra strength, Provial and no work restrictions were issued.

Petitioner continued to treat at Physicians Immediate Care until September 20, 2016. At that visit, Petitioner reported a pain level of 2 out of 10. Petitioner also reported some pain from the arch to the sole of the foot and some discomfort at the proximal aspect of his left heel only in the middle of his work shift after a very busy day. Petitioner's exam was normal. Petitioner had a normal gait with no swelling present. Petitioner was discharged from care with only mild soreness mid-day when he is on his feet all day. Petitioner was released from care with no restrictions. (Px 1).

Petitioner testified his primary care physician, Dr. Gomez, referred him to Dr. Joshua Alpert in November of 2016. (T 18-19).

Petitioner presented to Dr. Joshua Alpert, of Midwest Bone & Joint Institute, on November 2, 2016. At that visit, Petitioner reported being injured at work when a forklift ran over his left foot. Petitioner also reported he had not undergone any treatment. Petitioner further reported pain wearing a shoe and standing for more than 2 hours in the bottom of his foot. The exam noted no effusion, normal range of motion, negative Thompson Test and squeeze test. Dr.

Alpert reviewed x-rays of the left foot which showed no evidence of obvious fractures or dislocations. Dr. Alpert diagnosed a left foot contusion, recommended physical therapy and allowed Petitioner to continue working full duty. Dr. Alpert stated Petitioner was to return in a month and, if no improvement, he would order an MRI at that time. (Px 2). Petitioner attended physical therapy at Team Rehabilitation from November 8, 2016 through January 3, 2017. (T 20).

Petitioner returned to Dr. Alpert on November 20, 2016 reporting pain in the medial arch of his anterior talus. The exam noted full range of motion and diffused pain over the anterior talus and the 2nd, 3rd, and 4th metatarsal head as well as over the plantar fascia. Dr. Alpert ordered an MRI of the left foot. On January 23, 2017, Petitioner followed up with Dr. Alpert reporting pain in the bottom of his foot. The exam noted pain over the plantar fascia and diffused pain over the foot. Dr. Albert reviewed the MRI which was found to be completely normal. Dr. Albert noted that Petitioner's symptoms were consistent with plantar fasciitis with pain on the base of the foot. (Px 2)

On March 6, 2017, Petitioner returned to Dr. Alpert reporting diffused pain laterally over the 2nd toe. Dr. Albert noted Petitioner continued to work full duty. In his records, Dr. Alpert wrote he could not find any objective findings causing Petitioner's pain. Dr. Alpert recommended Petitioner see a podiatrist and he assessed Petitioner with left foot pain with plantar fasciitis from a work injury. (Px 2).

On April 12, 2017, Petitioner presented to Dr. Corey Jacoby, podiatrist, with Elgin Foot & Ankle Center. (PX4). Petitioner reported in August of 2016 a forklift ran over his foot at work. Petitioner also reported initially his pain was moderate but after a month the pain got worse and continues to get worse. Petitioner stated he was working light duty. Petitioner reported his whole-body hurts and he thinks his foot injury is to blame. The exam noted no edema, negative Babinski sign and the absence of a Tinels sign. Dr. Jacoby noted a sever POP to the left metatarsal heads 1-4 with the 1st being the most significant. Dr. Jocaby also noted Petitioner was guarded during the exam retracting his foot frequently making a detailed exam very difficult. Dr. Jocaby further noted Petitioner reported pain in the plantar of the foot, pain with range of motion, pain within the plantar fasola central and medial band at the midfoot. X-rays were taken that Dr. Jocaby indicated showed bipartite tibial sesamold or sesamold fractures. In his records, Dr. Jocaby indicated the x-ray showed a sesamold abnormality which could be

incidental and congenital or an AVN fracture. Dr. Jacoby assessed sesamolditis vs. sesamold fracture vs. AVN left foot and left foot pain. Dr. Jacoby ordered an MRI. (Px 4).

Petitioner returned to Dr. Jacoby on May 12, 2017. At that visit, Petitioner reported his whole body hurt and he thinks his foot injury is to blame. Dr. Jacoby noted at the last visit he had ordered an MRI, but Petitioner said that he already had an MRI, so he did not obtain another MRI nor did he bring the prior MRI or know where it was done. Petitioner further reported his pain was so bad his leg occasionally gives out. Dr. Jacoby noted no erythema or paronychia or ecchymosis were present. In his records, Dr. Jacoby said it was very difficult to perform an exam because when Petitioner walks into the office in and out of the office in no pain or discomfort but during the exam, upon gentle touching, he pulls back and states it hurts. Dr. Jacoby stated the area that appears to have the most pain was the sub metatarsal heads 1-5 but it was difficult to assess because when distracted he could press on the area without a response but when Petitioner was not distracted, he reported severe pain. (Px 4)

Dr. Jacoby assessed a crush injury to the left foot and pain to the left foot. Dr. Jacoby noted Petitioner's exam was very mixed and his MRI was negative. At that visit, Dr. Jacoby recommended Medrol dose pack and Petitioner said he didn't want it but when Petitioner was about to walk out, he then wanted the medication. Dr. Jacoby noted Petitioner could walk into any out of the office without a limp or discomfort and the MRI was negative. Dr. Jacoby recommended work hardening to determine if Petitioner requires work restrictions. (Px 4).

On July 20, 2017, Petitioner returned to Dr. Jacoby reporting pain in his foot was spreading up his leg and life was becoming very difficult and he wanted to work less because, he felt, working was causing his pain. At that time, Dr. Jacoby noted it was difficult exam Petitioner because he can walk into and out of the office without a limp or pain or discomfort but when you tried to palpate Petitioner's foot, he pulls back and claiming to be in severe pain but when distracted Dr. Jacoby can palpate Petitioner's foot and ankle. Dr. Jacoby noted the area of significant painful appears to be under the medial sesamoid but that it was difficult to exam because whenever Petitioner about to be touched he would instantly pull his foot back and claim to be in severe pain. Dr. Jacoby recommended work hardening, replace his work shoes with an orthotic that would offload the sesamolds and he prescribed Tramadol. In his records, Dr. Jacoby wrote that Petitioner was not pleased with his recommendations because Petitioner wanted surgery. (Px 4).

Petitioner returned to Dr. Dr. Jacoby on November 15, 2017. At that visit, Petitioner reported now having hip, groin, ankle and knee pain. Dr. Jacoby noted the exam was very difficult to perform because Petitioner guards against the exam and even against light pressure. Dr. Jacoby noted Petitioner was unable to stand barefoot and put any pressure on his foot, but he was able to walk into and out of the office with a non-antalgic gait. Dr. Jacoby reviewed the prior MRI and noted it showed some bone marrow edema of the tibial sesamold that could be sesamolditis from a crush injury, but Petitioner makes the physical exam very difficult to fully perform. Dr. recommended replacing Petitioner's shoes, a steroid injection of the left 1st MTPJ but Petitioner refused the injection. Dr. Jacoby ordered work hardening to determine possible work restrictions. Dr. Jacoby noted Petitioner didn't want the injection he just wanted to be taken off work. Dr. Jacoby also recommended a possible second opinion. (Px 4).

On April 9, 2018, Petitioner returned to Dr. Alpert who noted that he had not seen Petitioner in a year. Petitioner stated he wanted to be reevaluated for ongoing complaints of left foot pain. The exam noted diffused left ankle pain with range of motion and pain over the middle of the ankle joint and diffused pain in the bottom of the foot. Dr. Albert assessed left ankle injury from August of 2016 with ongoing symptoms of pain and left foot plantar fasciitis. Dr. Albert recommended a cortisone injection which Petitioner refused. Dr. Albert also prescribed pain cream and recommended an exam with a podiatrist. (Px 2).

On June 15, 2018, Petitioner presented to Dr. Kyle Peterson, DPM, FACFAS, of Suburban Orthopaedics. At that visit, Petitioner reported being involved in a work accident on August 18, 2016 after his foot was run over by a forklift tire. Petitioner stated he reported the accident that same day[1]. Petitioner stated he was in constant pain all over the left foot that radiates up the leg. Petitioner also stated his foot swells throughout the day, and he had difficulty walking. Petitioner reports spasms and cramping in his foot and light numbness in the toes. X-rays were taken which showed normal alignment, no fractures, no dislocations no degenerative changes no loose or foreign bodies and no congenital abnormalities. Dr. Peterson assessed left foot and ankle pain, crush work injury of the ankle and ATFL sprain. Dr. Peterson ordered an MRI, OTC NSAIDs, and he indicated Petitioner could continue to work full duty with restrictions. (Px 6)

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[1] Petitioner testified he was injured on a Saturday but did not report the injury until the following Monday. (T 14).

Report of Dr. Holms, Respondent's Section 12 examiner

On July 26, 2018, Petitioner was examined by Dr. George Holms, pursuant to Section 12 of the Act. Petitioner reported his foot was run over by a forklift. Petitioner complained of pain over the entire dorsal aspect of the foot. The exam noted full range of motion. The exam also noted no Frank Tinel's. Dr. Holmes reviewed Petitioner's medical records from Physicians Immediate Care, Dr. Alpert, MRI dated December 31, 2016, and various podiatric treatment notes. (Rx 1)

Dr. Holmes opined that Petitioner did not sustain a musculoskeletal foot injury on August 10, 2016. [2] Dr. Holmes noted Petitioner's MRI was normal and there was no evidence of direct trauma in the initial x-rays and MRI scan. Dr. Holmes indicated there could be some neurologic injury but there was no collateral damage in the foot or ankle. Dr. Holmes opined Petitioner had subjective pain with no underlying verifiable etiology. Dr. Holmes testified the radiographs were normal and Petitioner was able to work 10 hours a day 4 days a week. Dr. Holmes indicated he was unable to find any objective parameter to explain Petitioner's subjective complaints. Dr. Holmes opined the orthopedic injury Petitioner may have sustained was, from a structural standpoint, completely resolved. (Rx 1)

Dr. Holmes opined there appears to be a causal relationship between the onset of symptoms but there does not appear to be any significant injury based upon the exams, x-rays and MRI. Dr. Holmes also opined that no further treatment was needed, Petitioner could return to work full duty without restrictions and was at MMI. Dr. Holmes opined Petitioner did not have frank plantar fasciitis and there were no objective parameters to support Petitioner's subjective complaints. (Px 1).

Other testimony

On August 31, 2018 Petitioner returned to Dr. Peterson. (T 29). Dr. Peterson continued to recommend Petitioner obtain a new MRI and that he could continue to work in the packing department. (T 29).

On November 16, 2018, Petitioner underwent a second MRI. (T: 29). The MRI was found to be normal but identified a "lateral malleolar edema with surrounding soft tissue edema".

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[2] Petitioner's date of injury is August 13, 2016. The Arbitrator finds the incorrect date involves a scrivener's error which does not adversely impact the weight of his opinions.

(PX 6). Petitioner testified he returned to Dr. Peterson, on November 30, 2018, who, at that time, recommended surgery. (T 29-30).

Testimony of Dr. Peterson:

Dr. Peterson testified he first examined Petitioner on June 15, 2018 and that Petitioner reported a forklift struck the lateral side of his left ankle and foot and the tire of the forklift also ran over his foot. Petitioner said he reported the injury that same and he was not able to work[3]. Dr. Peterson testified he noticed bruising and swelling to the lateral side of Petitioner's left ankle. Dr. Peterson testified Petitioner had an antalgic gait, tenderness to the medial and lateral aspect of the ankle including the ligament complex. (Px 9, pgs. 8-10). Dr. Peterson diagnosed ankle pain, crush work injury to the ankle and ATFL (anterior talofibular ligament) sprain. (Px. 9, pg. 11).

Dr. Peterson testified he reviewed the MRI, dated November 16, 2018, which, he opined, showed a true partial tear of the ATFL. Dr. Peterson recommended surgery consisting of arthroscopy, open Brostrom/Gould, and ORIF of the fibula stress fracture. (Px 9, pgs. 19-23). Dr. Peterson testified he took Petitioner off work. Dr. Peterson testified he disagreed with Dr. Holmes that there was no clear evidence of either ligament tear or stress fracture of the fibula. (Px. 9, pgs. 24, 32).

On cross exam, Dr. Peterson acknowledge he first saw Petitioner 22 months after the alleged accident. Dr. Peterson also acknowledged he did not review all of Petitioner's prior treatment records, diagnostic and radiographic images including the x-rays taken prior to his examination in June of 2018. (Px. Pgs. 36-41).

Dr. Peterson testified that it was his understanding one of the teeth of forklift impacted the lateral side of Petitioner's foot and ankle as well as the tire of the forklift ran over Petitioner's left ankle. Upon further questioning, Dr. Peterson admitted that history was not contained in any of his medical records. Dr. Peterson admitted Petitioner reported an inversion or twisting injury that was not contained in his medical records. (Px. 9, pgs. 42-44). Dr. Peterson testified he first documented clinical instability on August 31, 2018 and he acknowledged that he did not find any instability during his June 15, 2018 examination. (Px 9, pgs. 55-56).

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[3] Petitioner testified he was injured on a Saturday and completed his shift after being stuck by the forklift and he did not report the incident until taking his break on the following Monday.

Dr. Holms addendum report dated April 29, 2019

On April 29, 2019 Dr. Holms issued an addendum report after being provided additional medical records and radiographic studies including the MRI of the left foot taken on November 16, 2018. Dr. Holms testified the November 16, 2018 MRI, which was of poor quality, did not show any pathology requiring operative intervention as recommended by Dr. Peterson. Dr. Holms disagreed with Dr. Peterson's findings and conclusions regarding the November 16, 2018 MRI. Dr. Holms testified there were no features on the MRI or during his examination which would suggest Petitioner needs ligament reconstruction, open reduction, internal fixation of a fibula fracture or ankle debridement. Dr. Holms opined Petitioner sustained a contusion of the foot and that the records and radiographic studies taken after the accident showed no active fractures, dislocations or internal derangement. Dr. Holmes further opined Petitioner may of had some neurologic injury but, from a structural standpoint, there was no collateral damage in the foot and ankle. (Rx 2).

Other testimony:

Petitioner indicated he desires to undergo the surgery for the "well-being" of his left foot but is afraid. (T 30). Petitioner confirmed he continued to work for Respondent until the end of December 2018. (T30). Petitioner confirmed Dr. Peterson restricted him from all work. (T 31). Petitioner confirmed he has not worked since December 28, 2018. (T 31). Petitioner is not currently taking any medication. (T 31). Petitioner continued to use inserts in both shoes. (T 32). Petitioner confirmed that his pain level differs whether he is sitting or not sitting. (T 33). Petitioner claimed when he sits, his pain level is between a five and eight and when he stands it hurts the most. (T 33). Petitioner confirmed that before August 13, 2016 he suffered no prior accidents or injuries to his left foot. (T 33). Petitioner also confirmed he has suffered no subsequent accidents or injuries to his left foot. (T 33). Petitioner indicated he has had no income since December of 2018. (T 33). Petitioner indicated he lives with his brother who has helped him with money. (T 34).

The Arbitrator finds the Petitioner's testimony credible regarding the accident, but the Arbitrator does not find Petitioner to be credible regarding the nature and extent of his ongoing symptoms.

CONCLUSIONS OF LAW

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

The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992). To obtain compensation under the Act, the claimant bears the burden of showing by a preponderance of the evidence, he suffered a disabling injury which arose out of, and in the course of his employment. *Baggett v. Industrial Commission*, 201, Ill 2d. 187, 266 Ill. Dec. 836, 775 N.E. 2d 908 (2002).

With respect to issue "C" whether Petitioner sustained an accidental injury that arose out of and in the course of employment, the Arbitrator finds as follows:

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his injury "arose out of" and "in the course of" his employment. 820 *ILCS* 305/1(d) (West 2014). Both elements must be present to justify compensation. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill.App.3d 102, 105, 853 N.E.2d. 799, 803 (2006).

The requirement that the injury "arise out" of the employment concerns the origin or cause of the claimant's injury. *Sisbro, Inc. v. Industrial Comm'n*, 2017 Ill. 2d. 193, 203. 797 N.E.2d 665, 672 (2003). The occurrence of an accident at the claimant's workplace does not automatically establish that the injury "arose out of" the claimant's employment. *Parro v. Industrial Comm'n*, 167 Ill. 2d 385, 393, 212 N.E.2d 882, 885 (1995). Rather, "[T]he "arising out of" component is primarily concerned with causal connection and is satisfied when the claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury" *Sisbro*, 207 Ill. 2d at 203.

The Arbitrator finds that Petitioner proved by the preponderance of the evidence that he sustained and accidental injury that arose out of and in the course of employment. Petitioner testified that, on August 13, 2016, while working for Respondent, a forklift ran over his left foot. (T 12-13). Petitioner testified the forklift came from his left side and the tire ran over his left foot. (T 38-39). Respondent did not proffer testimony from any witness rebutting Petitioner's testimony regarding the accident. The testimony of the employee, if not impeached or rebutted, is sufficient to support an award. *Phoell Manufacturing Co. v. Industrial Comm'n*, 54 Ill.2d. 119,

295 N.E.2d 469, (1973). The Arbitrator also notes the initial medical records, from Physicians Immediate Care, collaborate Petitioner's testimony regarding the accident. The Physicians Immediate Care records dated August 15, 2016, state Petitioner's symptoms developed after a forklift ran over the top of his left foot while at work. (Px 1). The courts presume that when a person seeks treatment for an injury, he will not falsify statements to a physician from whom he expects to receive medical aid. *Shell Oil Co. v. Industrial Comm'n,* 2 Ill.2d 590, 592 N.E. 2d 224, 226 (1954).

With respect to issue "F", whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

When a worker's physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *Sisbro v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003). Workers need only prove that some act or phase of employment was a causative factor in her ensuing injuries. *Land and Lakes Co. v. Industrial Comm'n,* 359 Ill.App.3d 582, 592 (2005). The work-related task need not even be the sole or principal causative factor of the injury, as long the work is a causative factor. *See Sisbro,* 207 Ill.2d at 205. Even if the claimant has a preexisting degenerative condition which makes him more vulnerable to injury, recovery for an accidental injury will not be denied as long as she can show that her employment was also a causative factor. *Id.* At 205. Employers are to take their employees as they find them. *A.C.&S v. Industrial Commission*, 710 N.E.2d 8347 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (1982).

The Arbitrator has carefully reviewed and considered all medical evidence along with the testimony. The Arbitrator finds that Petitioner has not proven by the preponderance of the evidence that his current left foot condition is causally related to the work injury.

The Arbitrator finds the opinions of Dr. Holmes to be more persuasive than the opinions of Dr. Peterson. Dr. Holms reviewed Petitioner's treatment records and radiographic studies while Dr. Peterson testified he did not review Petitioner's prior treatment records and radiographic studies. (Px. Pgs. 36-41). The Arbitrator notes that Dr. Peterson examination found an antalgic gait and tenderness to palpations to the medical and latera aspect of the ankle including the ligament complex when diagnosing a partial tear of the ATFL and recommending surgery. The medical record from Petitioner's prior medical providers show that Petitioner did

not have an antalgic gait, Petitioner's reactions to palpations were inconsistent and Petitioner's reported symptoms and location of pain were also inconsistent. Dr. Jacoby noted that Petitioner did not have an antalgic gait. On May 12, 2017, Dr. Jacoby stated Petitioner was able to walk into and out of the office without a limp or discomfort. Dr. Jacoby also stated that it was difficult to exam Petitioner because, when distracted, Petitioner does not react to palpation but when not distracted Petitioner pulls his foot back and reports severe pain upon gentle touching. Dr. Jacoby noted that Petitioner was unable to stand barefooted and put any pressure on his left foot but was able to walk in and out of the office without any difficulty or appearing to be in any pain. Dr. Jacoby noted severe pain in the sub metatarsal heads 1-5 of the foot but Dr. Peterson noted severe pain in the medical and latera aspect of the ankle.

The Arbitrator also notes that Dr. Peterson's opinions and surgical recommendations were based, in part, upon the history and mechanism of injury reported by Petitioner. Dr. Peterson testified it was his understanding that one of the teeth of forklift impacted the lateral side of Petitioner's foot and ankle and the tire of the forklift also ran over his foot. Dr. Peterson testified Petitioner reported an inversion or twisting to his left ankle when it was impacted by the forklift. The Arbitrator notes that none of the prior treatment records indicate that Petitioner reported being struck on the side of his ankle by the tooth of forklift and the impact caused an inversion or twisting of his ankle. The Arbitrator finds that history and mechanism of injury relied upon by Dr. Peterson was not contained in his own medical records. On cross examination, Dr. Peterson admitted the history provided on direct examination was not contained in his medical records and his records do not document any an inversion or twisting of the left ankle. (Px. 9, pgs. 42-44). The Arbitrator finds that Dr. Peterson's opinions and treatment recommendations were based, in part, upon an inaccurate history and mechanism of injury and, as such, the Arbitrator finds the opinions of Dr. Peterson not to be persuasive. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-15 (First Dist. 2000).

Dr. Holmes opined there appears to be a causal relationship between the onset of symptoms but there was not significant injury based upon the exams, x-rays and MRI. Dr. Holmes opined no further treatment was needed, Petitioner could return to work full duty without restrictions and was at MMI. (Rx 1) Dr. Holmes also opined Petitioner sustained a

contusion of the foot and he may have had some neurologic injury but, from a structural standpoint, there was no collateral damage in the foot and ankle. (Rx 2).

With respect to issues "J" and "K" whether the medical services provided were reasonable and whether Petitioner is entitled to receive prospective medical care, the Arbitrator finds as follows:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n,* 409 Ill.App.3d 463, 470 (4th Dist. 2011).

The Arbitrator finds that Petitioner was at maximum medical improvement as of July 26, 2018, as determined by Dr. Holms. The Arbitrator notes that Respondent did not proffer testimony the medical treatment Petitioner received prior to the IME was unreasonable or unnecessary. As such the Arbitrator find the medical treatment Petitioner received prior to July 26, 2018 was reasonable and necessary to diagnose, relieve or cure Petitioner from the effects of his injury. As such, Respondent shall pay Petitioner for the medical treatment received prior to July 26, 2018 as identified in Petitioner's exhibits 1-9, pursuant to Sections 8(a) and 8.2 of the Act and subject to the Illinois Medical Fee Schedule.

The Arbitrator further finds that Petitioner failed to prove by the preponderance of the evidence that he is entitled to prospective medical care. As stated above, the Arbitrator found the opinions of Dr. Holmes to be more persuasive than the opinions of Dr. Peterson. Dr. Holmes opined the November 16, 2018 MRI did not demonstrate any pathology that would require operative intervention as recommended by Dr. Peterson. Dr. Holmes testified there were no features on the MRI or during his examination of Petitioner which would suggest Petitioner needs ligament reconstruction, open reduction and internal fixation of a fibula fracture nor does Petitioner need ankle debridement. Dr. Holmes opined Petitioner was at MMI as of July 26, 2018.

With respect to issue "L" whether Petitioner is entitled to TTD benefits, the Arbitrator finds as follows:

Petitioner is seeking TTD benefits from December 30, 2018 through January 31, 2020. (Arb. Ex. #1).

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, "*i.e.*, until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MM.I. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at 28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *Gallentine*, 201 Ill. App. 3d at 887; *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

As stated above, the Arbitrator found that Petitioner's condition of ill-being stabilized as of July 26, 2018, the date Dr. Holmes found Petitioner to be at maximum medical improvement. As such, the Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that he was entitled to temporary total disability benefits from December 30, 2018 through January 31, 2020.

With Respect to issue "M" penalties and fees, the Arbitrator finds as follows:

Illinois courts have refused to assess penalties under sections 19(k) and (l) of the Act where the evidence indicates that the employer reasonably could have believed that the employee was not entitled to the compensation withheld. *See, Board of Education v. Industrial Commission*, 93 Ill.2d 1, 442 N.E.2d 861 (1982); *See also, Avon Products, Inc. v. Industrial Commission*, 82 Ill. 2d 297 (1980) and *Brinkmann v. Industrial Commission*, 82 Ill. 2d 462 (1980). "Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay, and the standard we hold him to is one of objective reasonableness in his belief." *Id. See also, City of Chicago v. Industrial Commission*, 63 Ill. 2d 99 (1976). An employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act. *Matlock v. Industrial Commission*, 321 Ill.App.3d 167 (1st D. 2001). Further, penalties are generally not imposed when there are conflicting medical opinions or when an employer acts in reliance upon responsible medical opinion. *Matlock v. Industrial Commission*, 321 Ill.App.3d at 173.

The Arbitrator finds that Respondent reasonably relied on the Section 12 reports of Dr. George Holmes as a basis for refusing to pay Petitioner temporary total disability benefits and authorizing surgery prescribed by Dr. Scot Peterson. Thus, the Arbitrator denies the award of any penalties under Section 19(k) and 19(l) and denies the award of any attorney fees under Section 16.

With respect to issue "O" What is the nature and extend of the injury, the Arbitrator finds as follows:

The parties stipulated that if Petitioner has been found to be at MMI the Arbitrator should address the nature and extent of Petitioner's injury. (Arb. Ex. #1).

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

- (i) The reported level of impairment;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

With regards to paragraph (i) of Section 8.1(b) of the Act:

i. The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. This factor carries no weight in the permanency determination.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner was employed in a manufacturing company as a maintenance worker and his job duties included sweeping, mopping and packing boxes. Petitioner had to lift boxes with product weighing twenty-five to fifty pounds and he must be on his feet for 10-hour shifts. Petitioner sustained a crush injury of the left foot when a forklift ran over his foot. Petitioner's employment requires Petitioner to be on his feet a significant time during the day and he would be at risk for further incidents with forklifts. As such, the Arbitrator gives this factor significant weight in the permanency determination.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner was 46 years old. The Arbitrator considers the Petitioner to be a younger individual and concludes that Petitioner will likely have to work with his disability for a longer period of time than an older individual. As such, the Arbitrator gives this factor moderate weight in the permanency determination.

With regards to paragraph (iv) of Section 8.1(b) of the Act:

iv. Petitioner did not return to work for Respondent or for any other employer. Petitioner has not sought light duty or sedentary employment or any employment. Other than claiming entitlement for TTD benefits, Petitioner proffered no evidence that his future earning capacity is diminished by this injury. However, the Arbitrator noted Petitioner was able to return to work and testified he was given modified work by Respondent. When discharged from care from Physicians Immediate Care on September 20, 2016, reported some pain from the arch to the sole of the foot and some discomfort at the proximal aspect of his left heel after a very busy day. The Arbitrator notes that Petitioner's complaints would result in Petitioner seeking other employment which could impact Petitioner's future earning capacity. As such, the Arbitrator gives this factor moderate weight in the permanency determination.

With regards to paragraph (v) of Section 8.1(b) of the Act:

v. Evidence of Petitioner's injuries in the medical records shows that Petitioner suffered a contusion or crush injury of the left foot with ongoing subjective complaints of pain. Dr. Holms opined Petitioner sustained a contusion of the foot and some neurologic injury but from a structural standpoint there was no collateral damage in the foot and ankle. The Arbitrator finds some of Petitioner's complaints were to be collaborated by the medical records. As such, the Arbitrator gives great weight to this factor in determining permanency.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all the above factors, the Arbitrator concludes that Petitioner has sustained a 20% permanent loss of the left foot under Section 8, or 33.4 weeks of PPD benefits which Respondent is entitled to a credit in the amount of $1,084.33 for an advanced on PPD previously paid by Respondent.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC022978
Case Name	FIELD, JERRY v. THE AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0172
Number of Pages of Decision	19
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Bruce Wissore
Respondent Attorney	Julia Webb

DATE FILED: 4/21/2021

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

Jerry Field,

Petitioner,

vs. NO: 16 WC 22978

The American Coal Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability, and legal and evidentiary error, 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 28, 2020, is hereby affirmed and adopted.

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

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

No bond for removal of this cause to the Circuit Court is required as no award for payment has been entered. 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: **4/21/2021**
o: 3/18/21
BNF/wde
45

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Deborah L. Simpson*
Deborah L. Simpson

Dissent

I respectfully dissent from the majority decision and would reverse the Arbitrator's decision in its entirety. In so doing I find Petitioner's primary care physician, Dr. Alexander, to be more persuasive in his diagnosis of work-related pneumoconiosis. Dr. Alexander, in addition to being Petitioner's primary care physician, also performed pre-employment physicals on workers on Respondent's behalf. Dr. Alexander examined Petitioner on April 8, 2009 for a pre-employment physical prior to beginning his employment with Respondent. Dr. Alexander's treatment records contain numerous entries diagnosing Petitioner with CWP. Dr. Instanbouly also diagnosed Petitioner with CWP. I find their opinions much more reliable than those of Dr. Castle. In his records, Dr. Castle failed to notice most, if not all, of Dr. Alexander's entries diagnosing Petitioner with CWP. For these reasons, I would reverse the decision of the Arbitrator. Therefore, I respectfully dissent from the majority decision.

DATED:
o: 3/18/21
MP
68

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FIELD, JERRY
Employee/Petitioner

Case# **16WC022978**

THE AMERICAN COAL COMPANY
Employer/Respondent

On 5/28/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JERRY FIELD
Employee/Petitioner

Case # **16** WC **22978**

v.

Consolidated cases: **n/a**

THE AMERICAN COAL COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **HERRIN**, on **MARCH 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Sections 1(d)-(f) and 6 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 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 $**79,670.00**; the average weekly wage was $**1,532.20**.

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

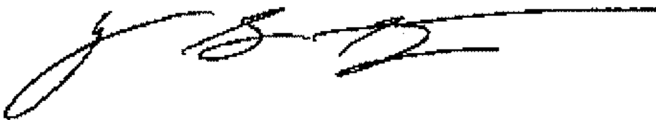
ORDER

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

No benefits are awarded.

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

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



Signature of Arbitrator

MAY 27, 2020
Date

MAY 2 8 2020

JERRY FIELD v. THE AMERICAN COAL COMPANY

16 WC 22978

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried in Herrin before Arbitrator Steffenson on March 13, 2020. The issues in dispute were accident, causal connection, the applicability of Sections 1(d)-1(f) of the Occupational Diseases (OD) Act, 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 and Transcript at 5-6).

FINDINGS OF FACT

Petitioner lives in Harrisburg, Illinois. He was 68 years old and married as of arbitration. Petitioner graduated from Carrier Mills High School. He had six months of diesel mechanic training at SIC during a layoff. He did not receive any degree or certificate. Petitioner worked for 30 years in the coal mine with those years being underground. In addition to coal dust, he was regularly exposed to and breathed silica dust for 14 years. He also breathed roof bolting glue fumes. Petitioner last worked a shift in the coal mine on May 22, 2015, for Respondent at its New Future Mine. On that date he was 62 years old and held the job classification of examiner. Petitioner testified that he was exposed to coal dust on that day. That was his last day at the mine because he was laid off. Petitioner testified that he was called back about a month after his layoff. He turned it down for health reasons and because he had started his UMW of A pension. Petitioner testified that one of the health reasons was breathing difficulties. On direct examination Petitioner testified he has not had any employment since leaving mining.

Petitioner started working in the coal mines in February 1975 for Peabody Coal Company. His first job classification was laborer. He was on the unit shooting compressed air at the face of the mine to knock the coal out of the wall to break it up. He testified that job did not create a lot of dust. He worked at that job for about a year and then became a brattice man where he built block walls for ventilation. Petitioner testified that this job was not bad as far as dust. Petitioner also shoveled on the belt. He testified that this job created a lot of dust

when he was in the air locks which he described as being between two brattices where the air would blow back on him. In 1979 Petitioner went to Classic Coal Company. He worked there firing shot, roof bolting and as a greaser. Petitioner testified that as a roof bolter he would pin up the roof in an area where they had cut out the coal. He would drill a hole in the roof, stick the glue tube in the hole and then insert the roof bolt into the hole and spin it to secure the roof. He testified that sometimes rock dust would come down on him as he was drilling holes in the roof. Petitioner testified that as the roof bolt would spin it would break the glue tube. The glue sometimes gave off a pretty strong odor. Petitioner was a roof bolter for 14 years. As a greaser, he was responsible for greasing the equipment. He also worked as a utility man and scoop operator at Classic Coal. Petitioner testified that in his job as a greaser there was not any dust. Operating the scoop, he might run into dust while he was cleaning at the face, depending whether he was on the return side of the unit or the intake side. He worked at Classic Coal about a year and a half. The next mine where he worked was Brushy Creek. He was a roof bolter there. He also worked as a laborer where he moved the belts to different parts of the mine. He also worked as a utility man and brattice man at Brushy Creek. Petitioner next went to Harco Deep for about a year during a layoff. He then went to Brushy Creek as a roof bolter. Petitioner went to work for Respondent in 2009 and stayed there until he was laid off. At Respondent he was an examiner. In that job he would walk the belt and the returns as well as the intake. He went through the mine to make sure everything was running as it should. Petitioner testified that he was in all areas of the mine as an examiner. He testified that the longwall is a metal sheer that runs across the face of the mine 1,000 feet and drops the coal. He testified that when the coal dropped there was a lot of dust. The returns were dusty because the air from the longwall went down the return out of the mine.

Petitioner testified that he first noticed breathing problems at work about the last six months. He noticed that the more he walked, the shorter of breath he would become. He would have to stop and catch his breath. He testified that from the time he first noticed his breathing problems until he left the coal mine, they stayed about the same. Petitioner testified that since leaving the mine and up to the date of arbitration, his breathing problems have been about the same. Petitioner does not take any breathing medications. He testified that his breathing difficulty affects his ability to pick up anything heavy. If he is playing with his grandkids, he stops to rest and catch his breath. He testified that push mowing his yard causes problems. He testified that his yard is about three acres, but he does not push mow all of it; he just trims. He testified that he could walk a mile or two on level ground at a normal pace before becoming short of breath. He testified that he could climb ten stairs before having to take a break. Petitioner testified that Dr. Alexander was his treating physician. He testified that he never talked to Dr. Alexander much about his breathing problems. Petitioner testified that he was never a smoker. Petitioner testified that he has some trouble with his knee. He takes medication for gout and cholesterol.

After he left Respondent, Petitioner signed up for unemployment. Petitioner testified that he was going to be off work with foot surgery when he was laid off. Petitioner testified that when he was recalled to Respondent's mine, he was already collecting his pension. He testified that the mine where he was recalled to is now closed. He testified that he had 21 years with UMW of A which qualified for full pension, but it was reduced because he took it early.

On cross examination Petitioner testified that after he left work at Respondent, he worked for Professional Records Destruction driving a shredding truck. Petitioner also worked a bit for Galatia Township driving a truck. Petitioner testified that the income that he earned from Professional Records Destruction and Galatia Township, was not enough to cause him to offset his pension or any other benefits. Petitioner testified that when driving the shredding truck, he would go into businesses with a new trash can and take the full one and put it on the truck for recycling.

Petitioner testified that he was always honest with Dr. Alexander when he shared his complaints or lack of complaints. Petitioner testified that he told Dr. Alexander that he had black lung. Petitioner testified that his diagnosis of black lung dated back to 2004 or 2005. Petitioner worked at Black Beauty Mine for six months while employed with Custom Staffing. He left that mine when he was laid off in February 2002. After he was laid off, he filed a black lung claim against Custom Staffing. Petitioner testified that his current counsel represented him in that claim. Petitioner testified that he settled that claim for 12.5% of a man. Petitioner testified that he underwent a chest x-ray and was examined by Dr. Robert Cohen in Chicago in conjunction with that claim. He testified that Dr. Cohen performed testing on him for oxygen and blood. Petitioner testified that from time to time over the years that he was employed in coal mining, he underwent chest x-ray screenings by NIOSH for black lung. He testified that after the x-ray was taken, NIOSH would write to him and tell him what the x-ray revealed. He did not bring any of those letters with him to arbitration. Petitioner testified that he spends time with his grandchildren who live next door. He testified that he does not have any hobbies other than going on hikes through the Shawnee National Forest. He testified that he does not often go on hikes now because his knee is giving him problems. He testified that he has received a rooster shot in his knee, and they are trying to rebuild the cartilage. He testified that his knee has limited him in terms of what he can physically do. Petitioner testified that he walks for exercise.

Dr. Suhail Istanbouly examined Petitioner on June 21, 2016, at the request of Petitioner's counsel. (Petitioner's Exhibit 1 at 6). Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. (Petitioner's Exhibit (*hereinafter*, PX) 1 at 4).

Dr. Istanbouly testified that he handles all kinds of respiratory problems and sees patients of all ages. He testified that during the course of his practice, he has had numerous occasions to work with and treat coal miners or former coal miners. He treats the full spectrum of lung disease including emphysema, COPD, chronic bronchitis, asthma, coal workers' pneumoconiosis and lung cancer. (PX 1 at 5).

Dr. Istanbouly noted that Petitioner was a coal miner for 31 years. Petitioner was a lifelong never smoker. Dr. Istanbouly described him as having intermittent cough just for the past few weeks which was mild without significant sputum. (PX 1 at 8). Strenuous activity may trigger the cough. (PX 1 at 9).

Dr. Istanbouly noted in his report that Petitioner had a mild non-specific ventilatory limitation. He testified that the FEV1 of 78% and the FVC of 76% were both below the lower limit of normal under the *AMA Guides*. Dr. Istanbouly testified that by non-specific ventilatory defect he meant it could be an element of both obstructive and restrictive. (PX 1 at 9-10).

Dr. Istanbouly testified that he personally reviewed the chest x-ray of Petitioner. He testified that in his practice he reviews all the x-rays of his patients and develops his own opinions. After that he reviews the radiologist's report. (PX 1 at 10). Dr. Istanbouly testified that based on Petitioner's history, physical exam, pulmonary function testing and chest x-ray, Petitioner had early stage simple coal workers' pneumoconiosis. Dr. Istanbouly's only recommendation was avoiding any further coal dust inhalation to prevent the progression of Petitioner's pulmonary disease. Dr. Istanbouly testified that Petitioner's intermittent cough and mild exertional dyspnea are indications that he has damage to his lungs as a result of his coal mine exposure. He testified that the damage has been confirmed on the chest x-ray and pulmonary function testing. (PX 1 at 11).

Dr. Istanbouly testified that the gold standard for diagnosing coal workers' pneumoconiosis is pathologic review. (PX 1 at 14). He testified that if he reads an x-ray as positive for coal workers' pneumoconiosis and knows that the patient had a sufficient exposure to coal mine dust to cause that disease, those two things combined suffice for him to make a diagnosis of coal workers' pneumoconiosis. If, on the other hand, Dr. Istanbouly reads the chest x-ray as negative, that would not necessarily rule out the existence of coal workers' pneumoconiosis. Dr. Istanbouly agreed that a recent study showed that 50% or more of long-term coal miners are found to have coal workers' pneumoconiosis at autopsy even though during life it is not found radiographically. (PX 1 at 15).

Dr. Istanbouly saw Petitioner one time for the purpose of a workup for his state black lung claim. He testified that for several years he had performed an average of 5 to 7 such examinations a month. Those examinations were always at the request of the claimant's

attorney. (PX 1 at 16). Dr. Istanbouly testified that Petitioner related mild dyspnea on exertion. He testified that there are causes for that other than respiratory disease. Deconditioning would be one such cause. Petitioner related to Dr. Istanbouly that his last job in the mine was fairly physical. Petitioner did not relate to Dr. Istanbouly any problems in completing his job duties at the mine. (PX 1 at 17). Petitioner did not tell Dr. Istanbouly that he left his employment at the mine because of problems due to a diagnosis of respiratory disease. Dr. Istanbouly was not sure what Petitioner had done since leaving the mine to remain physically fit. Petitioner was not taking any breathing medications and there was no history of him having ever done so in the past. Dr. Istanbouly testified that he did not review any treatment records regarding Petitioner. (*Id.* at 18).

Dr. Istanbouly testified that Petitioner's oxygen saturation at rest was 94% which is normal. Dr. Istanbouly testified that the spirometry performed on Petitioner revealed an FEV1/FVC ratio of 76% which is normal. He testified that it is the position of the American Thoracic Society and the European Respiratory Society that one look to the FEV1/FVC ratio to determine whether obstruction is present. (PX 1 at 18-19). Dr. Istanbouly agreed that he followed the GOLD standard in diagnosing COPD. He testified that the GOLD standard looks to the FEV1/FVC ratio for a determination of COPD and, if that standard is applied to Petitioner's test results, he did not meet the standard for an obstructive defect. Dr. Istanbouly testified that in his clinical practice for someone age 50 or above, he considers an FEV1/FVC ratio to be normal if it is greater than 70%. (PX 1 at 19-20).

Dr. Istanbouly reviewed the interpretation of Petitioner's chest x-ray by Dr. Henry Smith. He was not provided with any other interpretation of chest imaging of Petitioner. Dr. Istanbouly is neither an A-reader nor a B-reader of films. (PX 1 at 20-21). When he interprets a film for black lung, he determines whether the film is positive or negative for black lung and if it is positive, he then characterizes it as mild, moderate or severe. He does not provide profusion ratings for the films he interprets. In Petitioner's case, he graded the film that he reviewed as early pneumoconiosis based on the whole clinical picture including symptoms, physical exam, pulmonary function testing and chest x-ray. Dr. Istanbouly testified that the abnormality on Petitioner's chest x-ray could have been present for decades. Dr. Istanbouly could not say that the film he reviewed had a profusion of 0/1 or 1/0. Dr. Istanbouly did not know how long Petitioner had suffered from the non-specific ventilatory limitation that he found. He testified that it could have been present for decades. (PX 1 at 21-22). Dr. Istanbouly's one diagnosis for Petitioner was coal workers' pneumoconiosis, early stage. (*Id.* at 22-23).

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted chest x-ray of Petitioner dated March 28, 2016. He interpreted the chest x-ray as positive for

pneumoconiosis, profusion 1/0 with P/P opacities in the mid to lower lung zones bilaterally. He found the film to be quality 1. (PX 2).

Records from NIOSH were admitted into evidence. A chest x-ray dated April 26, 1999, was interpreted by an A-reader as not having any parenchymal abnormalities consistent with pneumoconiosis. The A-reader noted tiny benign calcified granuloma in the right lung base. The same film was interpreted by a B-reader as being completely negative. (Respondent's Exhibit 3 at 10-11). A chest x-ray dated April 8, 2009, was interpreted by an A-reader and a B-reader as having no abnormalities consistent with pneumoconiosis. (Respondent's Exhibit (*hereinafter*, RX) 3 at 12-15). A chest x-ray dated July 19, 2011, was interpreted by two B-readers as not having any abnormalities consistent with pneumoconiosis. (RX 3 at 16-19).

Dr. Cristopher Meyer reviewed a PA chest radiograph dated March 28, 2016, from Harrisburg Medical Center. Dr. Meyer testified that the film was quality 2 due to underinflation. He testified that in this case there was no significance to the underinflation. (RX 1 at 40). Dr. Meyer testified that there were no small or large opacities on the film. He testified that there were no radiographic findings of coal workers' pneumoconiosis. (RX 1 at 40-41).

Dr. Meyer has been board certified in radiology since 1992. (RX 1 at 7). Dr. Meyer has been a B-reader since 1999. (RX 1 at 19). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the teaching course which is called the B-reader program. (*Id.* at 19-21). Dr. Meyer has recently been asked to have a more academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course and submitting cases for the B-reader training module and exam. (*Id.* at 32). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr.Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making the distinction between a 0/1 and 1/0 film. (*Id.* at 34-35).

Dr. Meyer testified that to become a B-reader one takes the weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing the practice examples. Dr. Meyer testified that the faculty is typically experienced senior level B-readers. Typically, after one takes the course, he then takes the B-reading exam. (RX 1 at 32-33). Dr. Meyer testified that the certifying exam is six hours long with 120 chest x-rays to be characterized. The pass rate for the examination runs roughly 60%. (RX 1 at 34).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or linear opacities and based on the size and appearance of those small opacities they are given a letter score. (RX 1 at 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. (RX 1 at 28). The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper lung zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. (*Id.* at 23). Dr. Meyer testified that the profusion is basically trying to find the density of the small opacities in the lung. (*Id.* at 30).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and a chest x-ray regarding Petitioner. (RX 2 at 18). Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. (RX 2 at 30). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. (*Id.* at 6). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis. (*Id.* at 6-7). Dr. Castle was first certified as a B-reader in 1985 and was continually certified as a B-reader through June 30, 2017. (*Id.* at 12). Dr. Castle testified that he passed all the B-reading recertification exams. (*Id.* at 52).

Dr. Castle reviewed a chest x-ray of Petitioner dated March 28, 2016, from Harrisburg Medical Center. (RX 2 at 25). Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. (RX 2 at 25-26). Dr. Castle testified that for a proper reading of a chest x-ray for black lung, the reader needs to identify the patient and the date on which the x-ray was done and then determine the quality of the film. Next, the reader must determine whether there are any opacities present. This is determined by comparing the subject film to the standard ILO classification films. If there are opacities, they are classified according to their shape and size. The reader also notes the lung zones in which they are located as well as the profusion. Dr. Castle testified that the reader compares the average amount that is seen in the lung zones to the standard films and classifies it as 0/1, 1/0, 1/1 or the appropriate profusion. (*Id.* at 26-27). Dr. Castle testified that profusion is important because that is the determination of whether the x-ray is positive or negative. (*Id.* at 27-28). Dr. Castle testified that 1/0 is the lowest profusion for a film to be positive. Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. He testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. Dr. Castle testified that the *Guides* state in Section 5.4b that the correlation of chest

imaging with physiologic measures of impairment is poor. Dr. Castle testified that the *Guides* do not use chest imaging as a factor, let alone a key factor, in the assessment of impairment. (*Id.* at 28-29).

Dr. Castle testified that generally there is not any clinical significance to subradiographic pneumoconiosis. He testified that subradiographic means that one has a finding of pneumoconiosis usually pathologically that does not show up on x-ray. In Petitioner's case his normal diffusion capacity of 89% means that he has a normal or intact alveolar-capillary membrane. One would expect the diffusion capacity to be abnormal if he had impairment related to coal workers' pneumoconiosis. The scarring of pneumoconiosis occurs in the alveolar-capillary membrane. (RX 2 at 29-30). Dr. Castle testified that it is extremely unlikely for simple pneumoconiosis to progress once the exposure ceases. (RX 2 at 31). Dr. Castle testified that the scarring of pneumoconiosis is permanent and will not disappear over time. He testified that the opacity size will not shrink. Dr. Castle agreed with the official statement of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible dust levels in the mine until he reaches retirement age. (*Id.* at 31-32).

Dr. Castle testified that in regard to the medical records that he reviewed, there was not any basis for the diagnosis of pneumoconiosis noted on April 3, 2014, by Dr. Alexander. Dr. Castle testified that if one does not have pathology, then one would be looking for an abnormal chest x-ray which would be expected to show changes of pneumoconiosis. There was no indication in the records that Dr. Alexander had made that diagnosis based upon an abnormal x-ray. (RX 2 at 32-33).

Dr. Castle testified that with regard to the testing by Dr. Istanbouly, Petitioner's lower limit of normal for his FEV1 would by 76%. (RX 2 at 33). Dr. Castle testified that according to the American Thoracic Society, one looks at the ratio of the FEV1 and the FVC to determine if an obstruction is present. If that ratio is reduced below the lower limit of normal, then it would be an indicator of some degree of obstruction. Dr. Castle testified that in the testing by Dr. Istanbouly, Petitioner's FEV1/FVC ratio was 76% which would be above the lower limit of normal. Dr. Castle testified that same ruled out obstruction for Petitioner according to the American Thoracic Society/European Respiratory Society Guidelines. (RX 2 at 34). Dr. Castle testified that on the spirometry performed at Methodist Hospital, Petitioner's FVC was in excess of 92% of predicted. He testified that based upon that finding Petitioner had no indication of restriction. (*Id.* at 34). Dr. Castle testified that if he applied Table 5.4 of the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition,* to the results of the pulmonary function testing performed on Petitioner at Methodist Hospital, he would fall in

Class 0 impairment. Based upon that testing, Petitioner was capable of heavy manual labor from a respiratory standpoint. (*Id.* at 36-37).

Dr. Castle testified that if Petitioner related an onset of intermittent cough approximately one year after he left the mine, it would not be causally related to his coal mine employment. Dr. Castle testified that cough is not considered to be an objective determinate of pulmonary impairment. (RX 2 at 37).

Dr. Castle testified that based upon a thorough review of all the data, he concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. He testified that Petitioner worked in or around the underground mining industry for a sufficient enough time to have possibly developed coal workers' pneumoconiosis if he were a susceptible host. He worked for 31 years in the mining industry and last worked in 2015 as a mine examiner. (RX 2 at 37-38). Dr. Castle noted that Petitioner was a lifelong never smoker. Petitioner did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. (RX 2 at 38). Dr. Castle testified that in the pulmonary function testing performed by Dr. Istanbouly, the post bronchodilator study was normal. There was a minimal reduction in the FVC and FEV1 in the prebronchodilator study. Dr. Castle testified that while the study from Methodist Hospital was technically invalid, when best efforts were reviewed, this study was entirely normal showing no evidence of obstruction, restriction or diffusion abnormality. (*Id.* at 39).

Dr. Castle testified that no matter what he saw on the chest x-rays, he could not rule out the possibility that Petitioner could have pneumoconiosis that could be found pathologically or at autopsy. (RX 2 at 47). Dr. Castle testified that recent studies have shown as many as 50% of long-term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by radiographic study during their life. (RX 2 at 48). Dr. Castle testified that the abnormality of coal workers' pneumoconiosis is basically trapped coal dust in part of the lung which ends up wrapped in scar tissue and can be accompanied by emphysema around it. He testified that the affected tissue itself cannot perform the function of normal healthy lung tissue. He testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring. (*Id.* at 52).

Petitioner filed a workers' compensation claim in 2003 against Custom Staffing Services alleging exposure to coal dust and injury to his lungs. Petitioner settled that claim for 12.5% body as a whole. As part of that claim, Dr. Robert Cohen interpreted a chest x-ray taken November 9, 2004, as positive for pneumoconiosis, profusion 1/0 with Q/Q opacities in the bilateral upper and middle lung zones. (RX 6).

Medical records of HMC Clinic were admitted into evidence. Petitioner underwent chest x-ray on April 26, 1999, which was interpreted by Dr. Hisham T. Youssef as revealing benign calcified granuloma in the right lung base. He gave the film a profusion of 0/0. (RX 5 at 215). Petitioner underwent spirometry on March 20, 2000. Same was normal. (RX 5 at 210). Petitioner was seen for evaluation on March 20, 2000, for possible lung disease. He had a history of working in the coal mine for approximately 20 years. Physical examination of the chest was clear without rales, rhonchi or wheeze. It was noted that Petitioner had abnormal pulmonary functions, but Dr. Alexander indicated that he thought this was a result of poor calibration of the machine he was tested on as well as incorrect age entered for Petitioner. (*Id.* at 194).

Petitioner underwent preemployment physical for Respondent on April 8, 2005. Petitioner denied history of asthma, emphysema, frequent lung infections or tuberculosis. He denied frequent chest colds, constant bothersome cough, sputum or phlegm between colds, difficulty breathing or shortness of breath or wheezing. (RX 5 at 201-203). Chest x-ray performed on April 8, 2009, was interpreted by Dr. Youssef as negative with a profusion of 0/0. (RX 5 at 200). Spirometry performed on April 7, 2009, was normal. (*Id.* at 197).

Petitioner was seen on March 28, 2014, with complaint of headache. His review of systems pulmonary revealed no dyspnea. Physical examination of the chest revealed the lungs were clear to auscultation. (RX 5 at 167-169). Petitioner returned on April 3, 2014. His active problems were noted to be anal fistula, basal cell face, coal workers' pneumoconiosis-state, hearing loss and internal derangement right knee. Physical examination of the chest revealed his lungs clear to auscultation. (RX 5 at 164-166). Petitioner returned on April 14, 2014 at which time his active problems remained the same. Petitioner denied dyspnea. Review of systems, however, revealed dyspnea but no cough or wheezing. Physical examination of the chest revealed rales/crackles without wheeze or rhonchi. (*Id.* at 154-158). Petitioner was seen on April 30, 2014, complaining of right shoulder pain with onset two days prior at home. (*Id.* at 150-153).

Petitioner was seen on May 11, 2015, for history and physical for foot surgery. Active problems included coal workers' pneumoconiosis-state. Petitioner was noted to be a never smoker. From a functional standpoint, Petitioner had no physical disability and no difficulty with the activities of daily living. Review of systems pulmonary revealed no dyspnea or cough. Physical examination of the chest revealed no adventitious sounds. (RX 5 at 131-135). Petitioner was seen on January 25, 2016, for evaluation for possible gout. Review of systems pulmonary revealed no dyspnea, cough or wheeze. Physical examination of the chest revealed no adventitious sounds. (RX 5 at 128-130). Petitioner returned to the office on February 15, 2016. His active problems again included pneumoconiosis-coal workers'. His review of systems

pulmonary revealed no dyspnea or cough. (*Id.* at 122-127). Petitioner was seen on October 21, 2016, for blood pressure check. It was noted that Petitioner was working full time. (*Id.* at 115-116). Petitioner was seen on February 6, 2017. It was charted that he suffered from no dyspnea and suffered no chronic cough. Review of systems respiratory was negative for dyspnea, cough and wheeze. Physical examination of the chest was normal with no adventitious sounds. The assessment included coal workers' pneumoconiosis. (*Id.* at 110-114). Petitioner was seen in the office on May 8, 2017, for a DOT physical. Petitioner was noted to have no systemic symptoms, including pulmonary symptoms. Review of systems pulmonary was negative for dyspnea, cough or adventitious sounds. The assessment was routine history and physical. He was found fit for work and given a two-year DOT certificate. (*Id.* at 106-109). Petitioner was seen on July 10, 2017, complaining of back pain. He was noted to be working full time. His review of systems pulmonary was negative. Physical examination of the chest was normal with no adventitious sounds. (*Id.* at 103-105). When Petitioner was seen on February 7, 2018, he denied dyspnea, shortness of breath or wheeze. It was charted that Petitioner was retired from work. His review of systems respiratory was negative for dyspnea or cough. Physical examination of the chest was normal with no adventitious sounds. The assessment was coal workers' pneumoconiosis, hyperlipidemia and gout. (*Id.* at 97-102).

Petitioner was seen on February 18, 2019, for follow up regarding his hyperlipidemia and gout. His review of systems respiratory revealed no dyspnea or cough. Physical examination of the chest revealed normal breath sounds with no adventitious sounds. Dr. Alexander's assessment was coal workers' pneumoconiosis, elevated liver enzymes, hyperlipidemia and gout. (RX 5 at 47-52). Petitioner was seen on August 14, 2019. His review of systems respiratory revealed no dyspnea or cough. Physical examination of the chest revealed normal breath sounds with no adventitious sounds. The assessment included coal workers' pneumoconiosis. (RX 5 at 25-30).

CONCLUSIONS OF LAW

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

Issue C: *Accident*

Petitioner has failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. The Arbitrator finds the B-readings of Drs. Meyer and Castle, as well as the independent NIOSH B-readings, to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis were impressive and beyond that of Petitioner's physician, Dr. Istanbouly, who is not a B-reader. Dr. Cohen interpreted chest x-ray dated November 9, 2004 for Petitioner's prior black lung claim finding only Q type opacities in the bilateral upper and mid lung zones. Dr. Smith interpreted chest x-ray dated March 28, 2016 finding only P type opacities in the bilateral mid and lower lung zones. If accurate, this would mean that over time the opacities present shrank in size and disappeared from the upper lung zones. The evidence presented is that coal workers' pneumoconiosis is permanent and the opacities which result from same will not shrink in size or disappear from lung zones over time.

Issue F: *Causal connection*

Based upon and in addition to the findings regarding **Issue C**: above, Petitioner also has failed to prove by a preponderance of the evidence that his current condition of ill-being is causally connected to his employment.

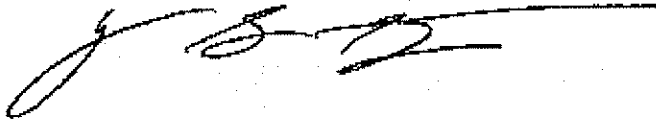
Issue L: *Nature and extent of injury*

Based upon the findings regarding **Issue C**: and **Issue F**: above, the nature and extent of injury is moot, and no benefits are awarded.

Issue O: *Sections 1(d)-1(f) of the OD Act*

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

disablement under the Act, Petitioner must show that he suffered an impairment in the function of the body or the event of becoming disabled from earning full wages as a coal miner as the result of an occupational disease. Dr. Castle testified that if the results from the last pulmonary function testing performed on Petitioner were applied to Table 5-4 of the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, Petitioner would fall in Class 0 impairment. Dr. Castle testified that from a respiratory standpoint, Petitioner is capable of heavy manual labor. To meet the second prong of the definition of disablement, Petitioner must prove that but for his occupational lung disease, he would have continued his coal mining employment. *Dawson v. Workers' Compensation Comm'n*, 382 Ill. App. 3d 581 (5th Dist. 2008). Petitioner testified that he worked for Respondent until he was laid off on May 22, 2015. There was no evidence in the record that any physician took Petitioner off work as a result of an occupational disease. As such, no benefits are awarded.



Signature of Arbitrator

MAY 27, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC032848
Case Name	RIVERA, CRESCENCIO v. BERRY PLASTIC CORP
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0173
Number of Pages of Decision	11
Decision Issued By	Deborah L. Simpson, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Joseph Zwick

DATE FILED: 4/21/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRESCENCIO RIVERA,

Petitioner,

vs. NO: 11 WC 32848

BERRY PLASTICS CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner's repetitive work activities caused him to sustain a right hand injury manifesting on August 19, 2011.

I. Findings of Fact

Petitioner began working for Respondent in 2003 and transitioned into a set-up man/packer position in 2010. As a set-up man, Petitioner had to set up Respondent's printing machine, which involved changing the machine's plates. Petitioner testified that it would take two to three hours to complete a set-up on the machine and he could perform more than one set-up per day.

To change the colors on a machine, Petitioner had to open the machine's heads by removing two T-pins per head. In doing so, Petitioner would pull the T-pin using his index and middle fingers, and occasionally his ring finger, on his right hand. Petitioner testified that he needed to use 30 to 35 pounds of force to remove each T-pin, which was three to four inches long. For each set-up, Petitioner moved 50 to 60 T-pins, and after he loosened the T-pins to move the heads, he had to use more strength to put the T-pins back in place by pushing them in with his palm.

In addition to the T-pins, Petitioner had to use horned tweezers to move a small triangle clip that was similar to a lock on the machine's plates. Petitioner testified that he removed eight to ten clips per set-up, and when removing the clips, he used force with his hand.

Once Petitioner's set-up work was finished, he would also work as a packer. Petitioner testified that he worked ten hours per day as a packer if there was not a set-up to perform and eight to nine hours per day as a packer if he had a set-up to do that day. The amount of time Petitioner worked as a packer varied depending on his set-up duties. However, Petitioner did not perform set-up tasks every day. When asked by the Arbitrator how many times out of 50 days of work would he not do set-ups, Petitioner's response was about three times.

Petitioner further testified that when he worked as a packer, he had to grab stacks of 200 lids from the rollers and put them on a table. He would then cut a bag, put the bag over the lids, and put it in a box that fit 20 stacks. Petitioner estimated that he packed one stack of lids every ten to 11 seconds, or six stacks per minute. After he packed 20 stacks into a box, Petitioner would close the box and push it to the conveyor railing before starting the process over again.

The bags that Petitioner used to wrap the lids were located above his head and similar to grocery store vegetable bags. To cut the bag, Petitioner used his right hand to reach above his head and pull the bag down with some force. Petitioner testified that he would pull down a bag every ten seconds, which equated to six bags per minute or 360 bags per hour.

A 30-minute job video of the tasks that Petitioner performed with the exception of his set-up duties was submitted into evidence along with a written job summary. The job summary in Respondent's Exhibit 4 listed the various physical demands of Petitioner's position and included some job duties that were not depicted on the job video, such as changing the plates.

Petitioner testified that he first noticed pain in his right hand around February 2011. He testified that moving T-pins made his hand pain worse, and he also felt hand pain while pulling the bags. On August 19, 2011, Petitioner presented to Dr. Phillip Gattas with complaints of right hand pain with finger swelling, numbness, and tingling primarily in the second and third digits. Petitioner told Dr. Gattas that his job required him to constantly pull plastic bags with his right hand, and due to this, he had gradually developed right hand pain that culminated on August 19, 2011 to a point where he could no longer take it. After right hand X-rays yielded structurally normal results, Dr. Gattas diagnosed Petitioner with hand pain.

Leading up to this visit, Petitioner was also treating for lumbar pain stemming from other work accidents on May 23, 2011 and August 14, 2011. The claims associated with these accidents, 11 WC 32850 and 11 WC 32849, were consolidated with the present matter along with Petitioner's fourth claim in 14 WC 31750, in which Petitioner alleged an additional repetitive trauma injury to his neck manifesting on December 4, 2012. The Commission has addressed each of Petitioner's four claims in separate Decisions.

At the August 19, 2011 visit, Dr. Gattas opined that Petitioner's low back and hand pain were related to his May 23, 2011 accident and his repetitive trauma injury manifesting on August 19, 2011. He noted that although Petitioner had demonstrated disability to his back and hand, he had been physically well and working without difficulty prior to the May 23, 2011 injury and the right hand pain culminating on August 19, 2011.

Petitioner thereafter began physical therapy for his right hand and low back on August 24,

2011. The physical therapist indicated that his findings were consistent with overuse injuries to the right hand and lumbar spine.

On September 1, 2011, Petitioner presented to Dr. Andrew Engel of Medicos Pain and Surgical Specialists with complaints of pain in his second and third fingers on his right hand, low back pain, and left greater than right leg pain. Dr. Engel diagnosed Petitioner with finger pain and lumbar herniated discs, kept him off work, and began his prescription medication management. He opined that Petitioner's finger pain was directly related to his work that required him to pull using his fingers. Dr. Engel indicated that he would focus on Petitioner's lumbar problem and defer to Dr. Gattas to treat the finger pain.

Petitioner was discharged from physical therapy for his right hand on September 15, 2011. At this time, the physical therapist reported that Petitioner no longer complained of middle and index finger pain. However, shortly thereafter on September 21, 2011, Petitioner told Dr. Gattas that his second and third digits had begun to swell again. Petitioner also complained of painful numbness and tingling, particularly in the second and third digits. On examination, Petitioner had positive Tinel's, Phalen's, and medial compression tests in his right hand. Dr. Gattas again opined that Petitioner's right hand condition was work-related. He recommended restarting physical therapy and referral to a hand specialist. Dr. Gattas also ordered a right hand MRI, which yielded unremarkable results on September 21, 2011.

On September 29, 2011, Petitioner presented to Dr. Richard Shin for a right hand consultation. Petitioner told Dr. Shin that he worked for eight years packing food items and pulling plastic bags with his right hand. Dr. Shin noted that Petitioner was righthand dominant. Dr. Shin found that Petitioner's right upper extremity symptoms were likely secondary to nonspecific flexor tenosynovitis and possible right carpal tunnel syndrome. He stated that it was unclear whether those conditions were related to his work activities, although they were not related to his back injuries sustained in May 2011 and August 2011. Dr. Shin recommended an EMG/NCV of the upper extremities, requested Petitioner's job description to review, and provided ten-pound lifting restrictions for the right hand.

The EMG/NCS, which was obtained on October 7, 2011, showed a neuropraxic lesion of the right median nerve at the wrist resulting in prolonged motor and sensory latencies with decreased sensory conduction velocities as well as a neuropraxic lesion of the left median nerve at the wrist resulting in decreased conduction velocities of sensory fibers.

On October 13, 2011, Dr. Shin found that the EMG had revealed right carpal tunnel syndrome and possible left carpal tunnel syndrome. Dr. Shin stated that it was still unclear whether Petitioner's right hand condition was related to his work, but his self-described work activities could be related. He again requested a review of Petitioner's job description and work history to better determine if his condition was work-related. Dr. Shin further recommended that Petitioner wear a wrist splint while sleeping and remain on ten-pound lifting restrictions. Petitioner testified that he subsequently returned to work from October 24, 2011 through April 19, 2012, but he continued to have pain in his hand, legs, neck, and back.

On November 3, 2011, Dr. Shin again recommended a review of Petitioner's job

description and kept Petitioner on ten-pound lifting restrictions. He then reiterated the same recommendations at Petitioner's follow-up visits in November and December 2011. Throughout this time, Petitioner also continued to treat and remain under restrictions for his lumbar condition.

On December 21, 2011, Petitioner presented to Dr. Robert Erickson of Lake County Neurosurgery with complaints of radicular leg pain. Although Dr. Erickson's focus was on Petitioner's lumbar and cervical issues relevant to his May 2011 and August 2011 accidents, he noted that Petitioner also reported chronic right hand pain due to repetitive gripping at work, as well as some neck stiffness and limited range of motion.

Thereafter, at Respondent's request, Dr. Michael Vender performed a §12 examination regarding Petitioner's right hand on January 5, 2012. Dr. Vender noted that Petitioner reported having right hand pain with numbness and tingling prior to injuring his back in May 2011. He obtained right hand X-rays that demonstrated mild degenerative changes in the IP joints and right wrist X-rays that demonstrated volar tilting of the lunate. On examination, Dr. Vender found tenderness at the index and middle finger A-1 pulley areas representative of a local flexor tendinitis. He diagnosed Petitioner with flexor stenosing tenosynovitis of the right index and middle fingers. Dr. Vender suggested that although electrodiagnostic studies were indicative of carpal tunnel syndrome, Petitioner needed to obtain repeat studies before a reliable diagnosis of carpal tunnel syndrome could be made.

Dr. Vender also indicated that he had reviewed Petitioner's 30-minute job video as well as his written job summary. He stated that although the activities demonstrated on the video had an element of repetitiveness, there were no significant forceful exertions. Therefore, Dr. Vender opined that Petitioner's work activities did not contribute to his flexor stenosing tenosynovitis or possible carpal tunnel syndrome. Despite finding no causal connection, Dr. Vender recommended injections into the flexor tendon sheaths of the index and middle fingers as well as a 40-pound restriction if lifting was performed intermittently.

On January 12, 2012, Dr. Shin indicated that contrary to Dr. Vender's diagnosis, Petitioner never voiced any complaints nor had signs of stenosing tenosynovitis at his examinations. Instead, Dr. Shin believed that Petitioner's symptoms were likely secondary to stabilizing nonspecific tenosynovitis and carpal tunnel syndrome in the right hand. Dr. Shin stated that these conditions were likely related to Petitioner's self-described work activities; however, he once again recommended a review of Petitioner's job description to better determine if the conditions were work-related. He also kept Petitioner on ten-pound lifting restrictions for his right hand. Dr. Shin then repeated these same recommendations at Petitioner's follow-up visits on February 9, 2012, March 8, 2012, and May 31, 2012.

Petitioner thereafter continued to treat for his lumbar and cervical injuries, which Petitioner related to his May 2011 and August 2011 accidents. He eventually underwent a L4-L5 hemilaminectomy on April 20, 2012 and was taken off work by Dr. Erickson postoperatively.

On July 3, 2012, Petitioner returned to Dr. Engel with complaints of radiating low back pain, neck pain, and numbness in his right first through third fingers. On examination, Petitioner's Tinel's and Phalen's signs were positive at the right wrist. Dr. Engel's diagnoses included carpal

tunnel syndrome, lumbar herniated discs and radiculopathy, and cervical herniated discs. Dr. Engel's treatment at this visit did not focus on the right hand; however, at Petitioner's later visit on July 27, 2012, Dr. Engel provided a referral instructing Petitioner to transfer care for his carpal tunnel syndrome from Dr. Shin to Dr. Steven Sclamberg.

Petitioner presented to Dr. Sclamberg of ONS Orthopaedics of the North Shore on July 31, 2012. Dr. Sclamberg diagnosed Petitioner with right carpal tunnel syndrome and recommended an open carpal tunnel release. In the interim before surgery, Dr. Sclamberg recommended physical therapy and restrictions of no repetitive work or lifting more than two pounds with the right hand. He opined that Petitioner's treatment had all been reasonable and necessary for his work-related injuries. Petitioner thereafter began additional physical therapy for his right hand.

On August 9, 2012, Dr. Engel reviewed Dr. Vender's §12 report and indicated that Dr. Vender had the wrong mechanism of action for Petitioner's accident. He stated that although Dr. Vender had reviewed Petitioner's job video, the light duty work depicted on that video was not the work that Petitioner performed. Instead, Dr. Engel stated that Petitioner did much heavier lifting and repetitive forceful grasping with his hands. He indicated that Petitioner lifted 25 to 68-pound cases repetitively over 1,000 times per day. Since he opined that Dr. Vender had the wrong job description and mechanism of action, Dr. Engel argued that the §12 report should be voided.

Petitioner testified that he thereafter returned to work with restrictions for three or four days sometime in August or September 2012. During this time, Petitioner did not perform his regular packing duties and instead worked six hours per day putting tape on the floor. Petitioner testified that he felt worse pain in his hand and neck during this time. Aside from this brief period of light duty, Petitioner never went back to work for Respondent.

On September 13, 2012, Petitioner complained to Dr. Engel of worsening low back pain after returning to work. Dr. Engel noted that Petitioner had low back pain that radiated down his left leg, neck pain, and numbness in his right second and third digits. Dr. Engel also stated that Petitioner was developing left hand numbness to his second and third fingers since he was only using his left hand at work. Dr. Engel took Petitioner off work and indicated that returning Petitioner to work had caused him to develop symptomatic left carpal tunnel syndrome as well.

Petitioner thereafter underwent the right open carpal tunnel release on October 9, 2012 and was kept off work by Dr. Sclamberg. When Petitioner returned to Dr. Engel on October 15, 2012, he complained of worsening right wrist pain, although the numbness in his second and third fingers was improving. Petitioner also reported that the left wrist pain with numbness in his second and third fingers was improving as well. Dr. Engel kept Petitioner off work and continued the medication management for his ongoing lumbar and cervical issues.

On October 23, 2012, Dr. Sclamberg ordered postoperative physical therapy for Petitioner's right hand and kept him off work. Thereafter on November 5, 2012, Dr. Sclamberg reviewed the video of Petitioner's job duties. Dr. Sclamberg opined that the repetitive actions in the video could be the cause and/or an aggravating factor of Petitioner's carpal tunnel syndrome.

On November 28, 2012, Dr. Sclamberg stated that he did not see anyone setting up the printing machine in the job video. Dr. Sclamberg noted that Petitioner had to adjust plates held in place by T-pins, forcefully grasp and pull T-pins, and push T-pins using his right palm in a repetitive fashion 20 to 70 times per day, or 150 to 245 times per week. He indicated that Petitioner also adjusted plates with pliers and a rubber mallet by repetitively striking the plates and forcefully grasping or twisting with the pliers. Dr. Sclamberg opined that Petitioner's current condition was related to his work activities as outlined by his job description and the job video.

When Petitioner returned on December 11, 2012, Dr. Sclamberg reported that Petitioner was doing very well with no complaints of right wrist pain. Dr. Sclamberg then discharged Petitioner and released him to full duty work for his right hand. He further noted that the previous treatment rendered had been reasonable and necessary for Petitioner's work-related injury. On the following day, December 12, 2012, Dr. Engel stated that it was clear that Petitioner's care had been medically necessary, given that Petitioner was now discharged to full duty work for his right hand. Nevertheless, Dr. Engel kept Petitioner off work for his lumbar and cervical issues.

Although Petitioner did not thereafter treat for his right carpal tunnel syndrome, he continued to treat, and be under work restrictions that eventually became permanent, for his radiating cervical and lumbar pain. Petitioner testified that he tried to find work after he was discharged by Dr. Erickson in October 2015 with restrictions, which were related to his other alleged work accidents and not his August 19, 2011 repetitive trauma claim. Petitioner never went back to work for Respondent, because Respondent's facility had permanently closed down on June 21, 2014. He eventually found work at ABM Janitorial in September 2016. Petitioner worked 32 hours per week at ABM Janitorial cleaning desks, sweeping, and vacuuming until September or October 2017, after which time he retired due to the pain in his legs, back, and neck.

Prior to proceeding to hearing, the parties deposed several of Petitioner's treating doctors and §12 examiners. Both Dr. Erickson and Dr. Goldberg provided opinions regarding Petitioner's lumbar and cervical conditions, which were the subject of Petitioner's other claims. As relevant to the present claim, the parties deposed Dr. Sclamberg, Petitioner's treating doctor, on December 8, 2014 and Dr. Vender, the §12 examiner, on February 20, 2015.

Dr. Sclamberg opined that Petitioner's right carpal tunnel syndrome was causally related to the job that Petitioner described to him and the job that he saw depicted on the job video. He testified that repetitively grasping, exerting stress, and twisting were characteristic of the types of actions that caused tendons to fire and put increase pressure on the carpal tunnel. Dr. Sclamberg testified that Petitioner did a lot of twisting, repetitive pushing/pulling, and repetitive duties over a sustained period of time. He put significance on the fact that Petitioner had been doing his job for nine years, as it was a long time to do the same thing repetitively and put pressure on the carpal tunnel nerve. Dr. Sclamberg opined that Petitioner's repetitive job duties and forceful grasping at least aggravated his condition, regardless of whether it was the only cause of the condition.

Dr. Sclamberg further testified that Petitioner's clinical complaints correlated with his diagnostic findings, because Petitioner had numbness and tingling in the distribution of the median nerve classically in the first through third fingers. Dr. Sclamberg noted that at Petitioner's December 11, 2012 visit, he was doing very well and had no complaints of right wrist pain after

undergoing carpal tunnel surgery. Dr. Sclamberg testified that Petitioner's improvement meant that he made the right diagnosis of carpal tunnel syndrome and performed the right surgery.

On the other hand, Dr. Vender testified that his diagnosis was flexor stenosing tenosynovitis of the right index and middle fingers as opposed to carpal tunnel syndrome. Dr. Vender further testified that the activities on Petitioner's job video involved the routine use of his hands and upper extremities. He opined that the activities in the job video and written job summary would not cause flexor tendinitis, stenosing tenosynovitis, or carpal tunnel syndrome.

Nevertheless, Dr. Vender agreed that repetitive, forceful gripping with the index and middle fingers could contribute to a diagnosis of flexor tenosynovitis if performed persistently. He testified that if Petitioner's work duties did in fact include significant forceful exertions beyond what was described at the deposition, his opinion regarding causation could change.

At the time of the hearing, Petitioner testified that his current hand pain gets to an increased level that it would not reach prior to February 2011. Petitioner testified that he takes ibuprofen, Naprosyn, and Aleve for pain; however, it was not specified in Petitioner's testimony whether he takes this medication for his hand pain or to manage his ongoing cervical and lumbar pain.

II. Conclusions of Law

Following a careful review of the entire record, the Commission reverses the Decision of the Arbitrator and finds that Petitioner's repetitive work activities caused him to sustain a right hand injury manifesting on August 19, 2011.

Based on Petitioner's testimony, job video, and written job summary, Petitioner established that his work activities required the repetitive and forceful use of his right hand. The Decision of the Arbitrator indicates that Petitioner only performed the set-up job where he worked with T-pins approximately once in every 50 workdays. However, the Commission finds that Petitioner's testimony established that he performed this forceful set-up task on a significantly more frequent basis. Specifically, when asked how many times out of 50 workdays he would not do set-ups, Petitioner's response was about three times. This equates to Petitioner performing set-ups on 47 out of 50 workdays, as opposed to only once during that timeframe.

Petitioner's testimony supports the finding that removing the T-pins was a forceful and frequent activity. Petitioner testified that for each set-up, he had to remove 50 to 60 T-pins. To do so, Petitioner pulled the T-pins with his index and middle fingers on his right hand using 30 to 35 pounds of force. Thereafter, Petitioner had to put the T-pins back in place by forcefully pushing them with his palm. Petitioner testified that it would take two to three hours to perform a machine set-up, and it was possible for him to complete more than one set-up per day. Since Petitioner performed at least one such set-up on 47 out of every 50 workdays, it amounts to a considerably repetitive and forceful job duty.

Moreover, Petitioner's written job summary in Respondent's Exhibit 4 contains several set-up tasks and physical demands not shown on the job video that could be considered forceful and repetitive. For example, the job summary states that Petitioner had to grasp 100-count stacks

of lids from a case 1,088 times per day and lift 25-pound cardboard cases 68 times per day. There was also no evidence rebutting Petitioner's testimony that he had to perform such tasks as forcefully using pliers to remove eight to ten clips per set-up or reaching above his head to pull down a bag every ten seconds.

In consideration of Petitioner's testimony as to the frequency of his set-up duties as well as the physical demands listed in his written job summary, the Commission finds that Petitioner's work activities were sufficiently forceful and repetitive. Furthermore, given that Dr. Vender failed to appreciate the forceful nature of Petitioner's job and instead categorized the work activities as merely routine, the Commission finds that Dr. Sclamberg offered the more persuasive opinion. Dr. Sclamberg opined that the current condition of Petitioner's right hand was causally related to his work activities as outlined by the written job summary and job video. The Commission finds that Dr. Sclamberg demonstrated sufficient knowledge of both the forceful and repetitive nature of Petitioner's job. Not only had Dr. Sclamberg reviewed Petitioner's job summary and job video, but his stated understanding of Petitioner's job duties was also consistent with Petitioner's testimony. Dr. Sclamberg's causal finding is further bolstered by the treatment notes of Dr. Gattas and Dr. Engel, who also opined that Petitioner's hand condition was related to repetitive trauma culminating on August 19, 2011.

The Commission also acknowledges that the records supports Dr. Sclamberg's diagnosis of carpal tunnel syndrome. The presence of carpal tunnel syndrome was confirmed by an EMG. Additionally, Petitioner's postsurgical improvement after undergoing the carpal tunnel release indicates that Dr. Sclamberg had pinpointed the right diagnosis. Despite these findings, Dr. Vender failed to recognize carpal tunnel syndrome as a reliable diagnosis, which further weakens his opinion.

For these reasons, the Commission finds that Dr. Sclamberg offered the more persuasive opinion, and therefore, finds that Petitioner's repetitive and forceful work activities caused him to develop right carpal tunnel syndrome.

Upon finding causation, the Commission awards all reasonable and necessary medical expenses related to the treatment of Petitioner's right hand condition incurred through the hearing date of May 20, 2019 pursuant to §8(a) and §8.2 of the Illinois Workers' Compensation Act. Following Petitioner's carpal tunnel release, Dr. Sclamberg discharged him to full duty with no complaints of right wrist pain on December 11, 2012. The success of this surgery indicates that it was a reasonable and necessary treatment option for Petitioner to pursue.

The Commission further finds that Petitioner is entitled to TTD benefits from October 9, 2012 through December 11, 2012. Prior to this period, Petitioner failed to establish whether he was off work due to his right hand condition or his cervical and lumbar conditions. For instance, the time Petitioner was off work beginning on April 20, 2012 is more accurately attributed to Petitioner's lumbar condition, given that he underwent a L4-L5 hemilaminectomy on that day. The record failed to clearly show that Petitioner was off work specifically for his right hand condition before he underwent the carpal tunnel release on October 9, 2012 and was taken off work. Petitioner was thereafter released to full duty for his right hand by Dr. Sclamberg on December 11, 2012. As this time period is clearly attributable to Petitioner's right hand condition,

the Commission awards TTD benefits from October 9, 2012 through December 11, 2012.

Lastly, the Commission finds that Petitioner sustained a 10% loss of use of his right hand. Since Petitioner's accident occurred before September 1, 2011, the Commission is not required to apply the §8.1b enumerated criteria when assessing the PPD award. Although Petitioner's condition necessitated a carpal tunnel release surgery, the Commission recognizes that Petitioner had successful post-surgical results. On December 11, 2012, Dr. Sclamberg indicated that Petitioner had no more complaints of wrist pain and released him to full duty work for his right hand. Nevertheless, although he did not thereafter seek additional treatment, Petitioner testified that his hand pain currently gets to a level that it would not reach prior to February 2011. Petitioner testified that he takes ibuprofen, Naprosyn, and Aleve for his current pain; however, it was not clearly specified whether Petitioner takes this medication for his hand pain or his ongoing cervical and lumbar pain. Given that Petitioner continues to have some lingering pain in his dominant hand despite his positive postsurgical results, the Commission awards 10% loss of use of the right hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated January 23, 2020, is hereby reversed as stated herein.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner's forceful and repetitive work activities caused him to sustain a repetitive trauma injury to his right hand with a manifestation date of August 19, 2011.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all reasonable and necessary medical expenses related to Petitioner's right hand condition incurred from the manifestation date of August 19, 2011 through the hearing date of May 20, 2019 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner TTD benefits of $383.10 per week from October 9, 2012 through December 11, 2012, which represents 9 weeks, in accordance with §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $344.79 per week for a period of 20.5 weeks pursuant to §8(e) of the Act, as the repetitive trauma injuries Petitioner sustained caused a 10% loss of use of the right hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: **4/21/2021**

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Marc Parker*
Marc Parker

DLS/met
O: 2/18/21
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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC032849
Case Name	RIVERA, CRESCENCIO v. BERRY PLASTIC CORP
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0174
Number of Pages of Decision	12
Decision Issued By	Deborah L. Simpson, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Joseph Zwick

DATE FILED: 4/21/2021

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: medical expenses	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRESCENCIO RIVERA,

Petitioner,

vs. NO: 11 WC 32849

BERRY PLASTICS CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. Findings of Fact

Petitioner was employed as a set-up man/packer for Respondent. On August 14, 2011, Petitioner was pushing a 70-pound box on a conveyor railing when he felt back and right leg pain radiating to his neck. The present matter, which covers the August 14, 2011 accident, was consolidated with Petitioner's three other cases, including 11 WC 32848, 11 WC 32850, and 14 WC 31750. The Commission has addressed each of Petitioner's four claims in separate Decisions.

Before starting his employment with Respondent in 2003, Petitioner had prior low back injuries and a low back surgery in 1988. Petitioner thereafter sustained another work accident in 1993 that required physical therapy and a motor vehicle accident in 1998 that required three additional months of physical therapy, after which Petitioner did not seek any other low back treatment until the work accidents now at issue. Petitioner continuously worked for Respondent without missing any days due to back pain from 2003 through May 2011.

Petitioner alleges that on May 23, 2011, he sustained lumbar and cervical injuries from bending over to pick up lids off the floor at work. The Commission addresses this May 23, 2011 accident in its Decision for 11 WC 32850. Following this injury, Petitioner presented to Concentra

Medical Center on May 24, 2011 with complaints of right-sided low back pain. Lumbar X-rays revealed spurs and degenerative disc disease at L4 to S1, degenerative facet arthropathy at L3 to S1, no spondylolisthesis or spondylolysis, and calcifications suggestive of renal calculi. Dr. Guntippar Pratumngern diagnosed Petitioner with a right sacroiliac sprain and prescribed Aleve, Tylenol, and Biofreeze. Petitioner was then released to regular duty.

When Petitioner returned to Concentra Medical Center on May 26, 2011, he reported improved symptoms. Dr. Cindy Ross indicated that Petitioner had met all of his treatment goals and again released him to regular duty work. Petitioner testified that he kept working after he was discharged, although his back pain was not gone.

Petitioner then sustained a second work accident, which is the subject of the present Decision, on August 14, 2011 while pushing a 70-pound box. On August 15, 2011, Petitioner presented to Concentra Medical Center with complaints of right low back pain radiating into his right leg. Dr. Ross diagnosed Petitioner with lumbar radiculopathy, prescribed ibuprofen and Biofreeze, and provided modified duty restrictions. When Petitioner returned on August 17, 2011, Dr. Ross indicated that Petitioner's pain was in his midline lumbosacral region and did not radiate. Dr. Ross diagnosed Petitioner with a lumbar strain, continued his medication, and kept him on modified duty. Petitioner testified that when he returned to work with restrictions after this visit, he noticed pain in his back, legs, neck, and hands.

Petitioner thereafter sought a second opinion at Marque Medicos on August 19, 2011, at which time he first told Dr. Phillip Gattas that he had right hand pain. Petitioner alleged a third work accident involving hand injuries due to his repetitive work activities manifesting on August 19, 2011. This accident is the subject of the Commission's Decision in 11 WC 32848.

Petitioner's complaints to Dr. Gattas on August 19, 2011 also included bilateral low back pain more pronounced on the left, numbness and tingling down the left lower extremity, and right hand pain with finger swelling, numbness, and tingling primarily in the second and third digits. Lumbar X-rays showed disc space narrowing between L5-S1 and L4-L5, an externally rotated right ilium, degenerative changes, and pelvic/sacral unleveling decreased toward the right with rotation and malposition of vertebral segments. Dr. Gattas diagnosed Petitioner with low back and hand pain. He opined that the conditions were directly related to Petitioner's May 23, 2011 work accident and repetitive trauma culminating on August 19, 2011.

On August 24, 2011, a lumbar MRI further revealed disc bulges with a superimposed right foraminal protrusion at L5-S1, bilateral neural foraminal stenosis at L4-L5, and right neural foraminal stenosis at L5-S1 along with postoperative changes at L4-L5 and sigmoid diverticulosis. Also on August 24, 2011, Petitioner began physical therapy for his low back and right hand.

Upon referral from Dr. Gattas, Petitioner presented to Dr. Andrew Engel of Medicos Pain and Surgical Specialists on September 1, 2011. Dr. Engel started Petitioner on prescription medication management for his herniated lumbar discs. Additionally, Dr. Engel opined that the May 23, 2011 accident was work-related and the direct cause of Petitioner's current pain.

Shortly thereafter, on September 9, 2011, an EMG/NCS showed acute denervation of the

left S1 nerve root with no peripheral entrapment or polyneuropathy. On September 19, 2011, Dr. Engel recommended left L4-L5 epidural steroid injections, which Petitioner underwent on October 5, 2011. When the lumbar injections failed to decrease Petitioner's left-sided pain, Dr. Engel referred Petitioner to Dr. Robert Erickson, a neurosurgeon, on October 12, 2011. Dr. Engel also continued Petitioner's medication management, physical therapy, and off-work restrictions.

Additionally on October 12, 2011, Dr. Edward Goldberg performed a §12 examination at Respondent's request to evaluate the May 23, 2011 and August 14, 2011 accidents. Dr. Goldberg diagnosed Petitioner with an aggravation of L4-L5 and possibly L5-S1 degenerative disc disease. He believed that Petitioner's bilateral leg pain was also from his disc degeneration emanating from L4-L5. Dr. Goldberg opined that Petitioner's condition was work-related to the May 2011 accident with an exacerbation in August 2011. He recommended an additional month of physical therapy and one to two injections, upon completion of which Petitioner would be at MMI and could work without restrictions. In the interim, he recommended a 10-pound lifting restriction with occasional bending, twisting, and reaching.

Petitioner thereafter returned to work from October 24, 2011 through April 19, 2012. During this time, on October 27, 2011, Dr. Engel recommended left L5-S1 epidural steroid injections, a month of physical therapy, and 10-pound lifting restrictions consistent with Dr. Goldberg's plan. Petitioner underwent the L5-S1 epidural steroid injections on November 9, 2011. On November 15, 2011, Dr. Engel continued Petitioner's medication management and reported that the injections had helped decrease Petitioner's pain.

On December 21, 2011, Petitioner presented to Dr. Erickson of Lake County Neurosurgery with complaints of radicular pain in both legs, worse on the left. Petitioner also reported chronic right hand pain due to repetitive gripping activity at work, as well as some neck stiffness and limited range of motion. Dr. Erickson opined that Petitioner's treatment to date was a direct result of a repetitive work injury on May 23, 2011. He recommended light duty restrictions and SSEP testing, which was also obtained on December 21, 2011. The SSEP testing of the lower extremities revealed bilateral L5 dermatomal conduction delays, and the SSEP testing of the upper extremities revealed bilateral C7 dermatomal conduction delays.

On January 5, 2012, Dr. Michael Vender performed a §12 examination at Respondent's request regarding Petitioner's right hand. His examination did not concern the lumbar and cervical injuries alleged from the August 14, 2011 accident covered in the present Decision.

On February 10, 2012, Dr. Erickson noted that the C7 bilateral delay shown on Petitioner's SSEP testing correlated with his perceived paresthesia. Regarding Petitioner's lumbar radiculopathy, Dr. Erickson further stated that there was a correlation between the SSEP testing and the MRI findings of collapse and mild listhesis at L4-L5. He indicated that there were bilateral L5 abnormalities, worse on the left side. As a result, Dr. Erickson recommended a L4-L5 hemilaminectomy beginning on the left side. He opined that the surgical recommendation was a result of Petitioner's work-related injury on May 23, 2011.

A cervical MRI obtained on February 14, 2012 further revealed a C5-C6 posterior disc/osteophyte complex that combined with facet disease to result in central canal and bilateral

neural foraminal stenosis. On March 16, 2012, Dr. Erickson noted that the MRI was positive for a C5-C6 herniation with moderate stenosis and mild cord compression. He opined that Petitioner's cervical problem should be corrected first with a C5-C6 anterior cervical discectomy and fusion before proceeding with the recommended lumbar treatment. Dr. Erickson indicated that his recommendations were the result of Petitioner's work-related injury on May 23, 2011.

On March 21, 2012, an UR certified the recommended left-sided L4-L5 hemilaminectomy as medically necessary. On April 11, 2012, Dr. Erickson explained that the approved lumbar surgery would begin on the left side with plans to decompress the right side as well, since Petitioner had bilateral pain and abnormalities. Petitioner thereafter underwent the recommended L4-L5 lumbar surgery on April 20, 2012. When Petitioner returned to Dr. Engel on May 1, 2012, his diagnoses were listed as lumbar herniated disc, lumbar radiculopathy, and cervical herniated disc. Dr. Engel indicated that he would treat Petitioner's neck pain after the low back pain had first been fully treated. He continued Petitioner's medication management and off-work restrictions.

On May 11, 2012, Dr. Erickson reported that Petitioner had significant improvement with his right-sided leg pain post-surgery, although he noted increased paresthesia. Dr. Erickson recommended physical therapy, which Petitioner promptly began for his lumbar spine.

On June 15, 2012, Dr. Goldberg performed a second §12 examination of Petitioner's lumbar spine at Respondent's request. Dr. Goldberg was not asked to address Petitioner's cervical condition at that time. In his corresponding report, Dr. Goldberg stated that although he appreciated that Petitioner had a legitimate injury, his examination had nonanatomic findings and did not correlate with L4-L5 pathology. Dr. Goldberg found that Petitioner was at MMI for his lumbar spine and could return to work without lumbar restrictions.

Petitioner then returned to Dr. Engel on July 3, 2012 with complaints of right-sided low back pain shooting to his right calf, bilateral neck pain, and numbness in his first through third fingers. Dr. Engel stopped Petitioner's physical therapy, as he felt Petitioner had plateaued. He then ordered a lumbar MRI, noting that Petitioner had new radiculopathy. The lumbar MRI, which was obtained on July 6, 2012, found disc pathology combining with facet disease to result in bilateral neural foraminal stenosis at L4-L5 and right neural foraminal stenosis at L5-S1. On July 12, 2012, Dr. Engel interpreted the MRI as showing L4-L5 neural foraminal stenosis secondary to a contained L4-L5 disc herniation abutting the right L4 nerve root. On the following day, July 13, 2012, an EMG/NCS yielded normal results with no evidence of acute denervation of the right-sided lumbosacral nerve roots, peripheral entrapment, or polyneuropathy.

On July 25, 2012, Dr. Erickson indicated that Petitioner had mild sensory change within the L5 dermatome and diagnosed him with residual L5 radiculopathy. SSEP testing performed on this date further showed significant evidence of bilateral L5, S1, and C6 dermatomal conduction delays. Dr. Erickson stated that the S1 delay suggested in the SSEP testing was not present intraoperatively, but the SSEP testing nevertheless correlated with Petitioner's MRI as to the C6 abnormality. Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-C6.

On August 9, 2012, Dr. Engel reported that Petitioner's low back pain had improved and his radicular symptoms had resolved, but he still had right-side low back pain, bilateral neck pain,

and numbness in his right second and third fingers. Dr. Engel continued Petitioner's medication management and off-work restrictions.

Petitioner testified that he thereafter returned to work with restrictions for three or four days sometime in August or September 2012. During this time, Petitioner did not perform his regular packing duties and instead worked six hours per day putting tape on the floor. Aside from this brief period of light duty work, Petitioner never went back to work for Respondent.

On September 13, 2012, Petitioner complained to Dr. Engel of worsening low back pain after returning to work. Dr. Engel noted that Petitioner had left greater than right low back pain that radiated down his left leg, left neck pain, and numbness in his right second and third digits. He stated that Petitioner had also developed left hand numbness to his second and third fingers, since he was only using his left hand at work. Dr. Engel then took Petitioner off work. Petitioner was also kept off work by the orthopedic surgeon treating his hand conditions, Dr. Steven Sclamberg, leading up to and after his right open carpal tunnel release surgery on October 9, 2012.

On November 6, 2012, Petitioner told Dr. Erickson that his neck pain had begun on May 23, 2011 when he lurched upward straining his neck at the same time that he felt the sudden back pain. Dr. Erickson then suggested that the prior SSEP testing may have erroneously noted a C6 abnormality when C7 was the correct abnormal nerve level. He recommended repeat SSEP testing to confirm the presence of C7 radiculopathy. On December 4, 2012, the repeat SSEP testing found bilateral C7 dermatomal conduction delays. On the same day, Dr. Erickson opined that the cause of Petitioner's neck problem and back pain was the original work-related accident of May 23, 2011. In 14 WC 31750, which is addressed by the Commission in a separate Decision, Petitioner also alleged a repetitive trauma injury to his neck with a manifestation date of December 4, 2012.

On December 12, 2012, Dr. Engel kept Petitioner off work for his lumbar and cervical issues, although he had been discharged to full duty for his right hand. Shortly thereafter, on December 14, 2012, Dr. Engel indicated that he had watched a 30-minute job video for Petitioner that showed repetitive work. Dr. Engel then opined that the repetitive nature of this work had helped cause Petitioner's conditions. On January 15, 2013, Dr. Erickson also reviewed the 30-minute job video and opined that it showed repetitive neck extension and twisting that likely led to Petitioner's cervical problem. His diagnosis at that time was C6 radiculopathy relative to a C5-C6 disc herniation. Dr. Erickson continued to recommend surgery and kept Petitioner off work.

At Respondent's request, Dr. Goldberg performed a §12 examination on February 1, 2013 focusing on Petitioner's cervical spine. Dr. Goldberg stated that Petitioner's MRI, which showed disc degeneration and an annular bulge to the right, did not explain why Petitioner had any left-sided symptoms. Additionally, Dr. Goldberg indicated that Petitioner had a positive Tinel's sign at both cubital tunnels that correlated with the numbness, tingling, and pain into his fourth and fifth digits. He did not believe that this finding was coming from a right C5-C6 annular bulge. Instead, Dr. Goldberg opined that it was possible Petitioner had sustained only a cervical strain in the May 23, 2011 accident. Although he found that the cervical treatment had been reasonable and necessary, Dr. Goldberg opined that Petitioner was at MMI for the cervical spine and could return to work without cervical restrictions.

On February 21, 2013, Dr. Engel reviewed Dr. Goldberg's §12 report and found it to be internally inconsistent. Dr. Engel argued that if Petitioner's pre-surgical treatment had been reasonable and necessary as Dr. Goldberg had opined, then the recommended cervical surgery must also be necessary. Dr. Engel continued to recommend cervical surgery with Dr. Erickson and kept Petitioner off work.

Shortly thereafter, on February 26, 2013, Dr. Goldberg authored a §12 addendum stating that he had interpreted Petitioner's cervical MRI to show mild disc degeneration without any herniation or stenosis. He further opined that Petitioner's disc bulge would not have been caused by his work accident.

On March 18, 2013, Dr. Erickson reported that Petitioner's lumbar surgery had significantly helped his low back pain, but his neck pain was now the chief concern. Dr. Erickson further stated that Dr. Goldberg had oversimplified Petitioner's C5-C6 herniation by finding that it did not explain his left-sided pain since it was central and right in location. Instead, he stated that the herniation was associated with mild cord compression and it was well-known that decussation or crossing of anterior spinothalamic tracts could cause contralateral pain. Dr. Erickson opined that Petitioner's herniation was best characterized as central, and as such, Dr. Goldberg's criticism was invalid.

At follow-up visits in April and May 2013, Dr. Engel kept Petitioner off work as they awaited approval for the cervical surgery. On July 25, 2013, Dr. Engel continued Petitioner's medication management and ordered a left L4 epidural steroid injection, which was subsequently administered on August 8, 2013. When Petitioner returned on August 19, 2013, Dr. Engel reported that his left-sided low back pain had improved post-injection. Dr. Engel noted that Petitioner's residual lumbar pain would now be addressed after his cervical pain had been treated with the recommended surgery. At this visit, as well as the follow-up visit on October 8, 2013, Dr. Engel kept Petitioner off work and prescribed Ultram.

On November 19, 2013, Petitioner saw Dr. Fernando Perez, a chiropractor, at Marque Medicos. Dr. Perez indicated that Petitioner was discontinuing his follow-up consultations with Dr. Engel, because Dr. Engel was no longer affiliated with Medicos Pain and Surgical Specialists. Instead, Dr. Perez stated that Petitioner's further treatment at Marque Medicos would be dependent upon Dr. Erickson's ongoing recommendations.

On December 18, 2013, Petitioner saw Dr. Leonard Kranzler at Northside Neurosurgery for a neurosurgical examination on behalf of Dr. Erickson. Dr. Kranzler stated that on May 23, 2011, Petitioner was lifting heavy objects when he felt low back pain and developed right hand pain with numbness, tingling, and weakness in his second and third fingers. Petitioner indicated that his pain was now in his neck radiating down both shoulders with numbness and tingling in his left hand, ring finger, and small finger. Dr. Kranzler referred Petitioner to pain management.

Petitioner presented to Dr. Sue Harsoor, a pain management doctor, on January 24, 2014. Dr. Harsoor diagnosed Petitioner with cervical and lumbosacral radiculopathy, kept Petitioner off work, and refilled his tramadol prescription. Petitioner then requested a cervical injection as he awaited approval for cervical surgery.

Shortly thereafter, on February 3, 2014, Respondent sent Petitioner a letter stating that it was permanently closing its facility, and as such, Petitioner's last date of employment would fall during a 14-day period beginning on April 7, 2014.

On April 9, 2014, Dr. Erickson reported that Petitioner's low back pain had improved as a result of his lumbar surgery, but his ongoing neck pain had persisted after many months. Petitioner also continued to complain of painful paresthesia radiating to the fourth and fifth fingers on his left hand. Dr. Erickson suggested that Petitioner pursue injection treatment until his cervical surgery was approved. On October 8, 2014, Dr. Erickson obtained repeat SSEP testing that yielded virtually identical results to the 2012 test with a slight progression on the left side and standard deviations at the C6 nerves. Dr. Erickson continued to recommend a C5-C6 anterior cervical discectomy and fusion, which he opined was a consequence of Petitioner's original work injury.

When Petitioner returned to Dr. Erickson on June 30, 2015, he complained of low back pain radiating to his left toes and neck pain radiating to his left fourth and fifth fingers. Dr. Erickson found that Petitioner's neurological examination was reassuring with no dermatomal sensory loss or clear atrophy. Nevertheless, Petitioner had diminished grip strength in the left hand, which Dr. Erickson opined was likely due to changes following his C5-C6 injury and disc herniation. Dr. Erickson's diagnoses at this time were lumbar and cervical spondylosis.

On August 5, 2015, Petitioner underwent an FCE that placed his capabilities at the light physical demand level and his position at the medium physical demand level. However, the evaluator stated that the FCE results were conditionally valid and represented Petitioner's perceived capabilities, even though he could physically do more. When Petitioner returned to Dr. Erickson on August 8, 2015, Dr. Erickson found that Petitioner was capable of lifting 15 pounds occasionally and 10 pounds frequently. Additionally, Dr. Erickson stated that Petitioner had C5-C6 neck problems following a work injury in September 2012 where a 40-pound box fell onto the left side of his head and shoulder. Dr. Erickson recommended a new cervical MRI and prescribed Ultram, Aleve, and ibuprofen.

On October 27, 2015, Dr. Erickson again referenced an alleged work injury that occurred after a box fell onto Petitioner's head. This treatment note listed the incident as occurring in September 2015, whereas the August 8, 2015 note said it happened in 2012. Dr. Erickson also indicated that he expected Petitioner's FCE restrictions to be permanent based upon the chronicity of his symptoms. He then put his plans to obtain a new cervical MRI on hold, since Petitioner's neck pain had receded, and prescribed tramadol and over-the-counter medication.

Petitioner testified that after he was discharged by Dr. Erickson in October 2015, he attempted to find work within his restrictions. Petitioner never went back to work for Respondent, as Respondent's facility permanently closed down on June 21, 2014. Petitioner eventually found work with ABM Janitorial in September 2016. Petitioner worked 32 hours per week at ABM Janitorial cleaning desks, sweeping, and vacuuming until September or October 2017. Petitioner testified that he then retired due to the pain in his legs, back, and neck. Petitioner has not looked for any other job since he stopped working around October 2017.

Petitioner returned to Dr. Erickson a final time on September 26, 2017 and reported difficulty after returning to work with a 20-pound lifting restriction. On examination, Petitioner complained of painful bending with flexion limited more than extension for the lumbar spine and paresthesia radiating to both feet with right-sided predominance. There was no dermatomal sensory deficit. Dr. Erickson recommended a 10-pound lifting restriction as well as no excessive bending, stooping, or lifting in a part-time capacity. Dr. Erickson indicated that further surgery was not being contemplated at that time, and instead, Petitioner was to continue treating with tramadol, Aleve, and ibuprofen. Petitioner was then instructed to return on an as-needed basis.

Prior to proceeding to hearing, the parties deposed Dr. Erickson, Dr. Goldberg, Dr. Sclamberg, and Dr. Vender. Both Dr. Sclamberg and Dr. Vender provided opinions concerning Petitioner's right hand condition, which is the subject of 11 WC 32848, and not Petitioner's low back or cervical conditions. As relevant to Petitioner's present claim, the parties deposed Dr. Erickson, Petitioner's treating doctor, on November 15, 2016 and Dr. Goldberg, the §12 examiner, on August 14, 2017.

Dr. Erickson testified that his diagnosis for Petitioner's lumbar spine was radiculopathy secondary to collapse and mild listhesis at L4-L5. He opined that given Petitioner's history of productive work activity for years after his pre-accident lumbar surgery, Petitioner's current condition was related to the May 23, 2011 and August 14, 2011 accidents. Dr. Erickson's understanding was that Petitioner was working successfully from 1998 through 2011 before his accidents. As such, he regarded the two work accidents as the probable cause of Petitioner's lumbar problems. Dr. Erickson testified that when he saw Petitioner on October 27, 2015, Petitioner still had back pain, albeit improved, and had restrictions that were likely permanent. He indicated that Petitioner was at MMI for his back at that time, but he made no determination regarding his grip strength or neck.

Regarding the cervical spine, Dr. Erickson's diagnosis was a significant disc problem at C5-C6 that was probably causative of Petitioner's upper extremity symptoms. Dr. Erickson testified that when he reviewed Petitioner's job video, it showed repetitive work above shoulder-height with neck extension. He testified that the repetitive activity depicted on the video was a possible cause of Petitioner's disc herniation. Dr. Erickson opined that Petitioner's cervical condition was a combination of acute and repetitive incidents, where repetitive activity weakened the disc and the herniation was perceived as an acute painful episode. He testified that Petitioner's cervical condition was causally related to his work activity based on the history Petitioner provided of a sudden onset of neck pain that was associated with repetitive twisting and lifting activity.

Finally, regarding the SSEP testing that Petitioner underwent, Dr. Erickson testified that it was becoming more universally accepted, although it was not commonly used in orthopedic literature and fellowships. He conceded that there was some controversy as to whether SSEP tests constituted the best or even a valuable test. Dr. Erickson further noted that there was some confusion on the cervical SSEP testing as to whether Petitioner had a C6 or C7 problem. At his deposition, Dr. Goldberg also testified that Petitioner's SSEP testing had been internally inconsistent, because it originally showed problems at C7 before changing to C6 in a later test. Dr. Goldberg testified that he did not use SSEP testing in his practice and would not consider it to be generally accepted among spine surgeons.

Dr. Goldberg further testified consistently with his §12 reports. Additionally, he testified that at the time of his second §12 examination on June 15, 2012, Petitioner could return to work without lumbar restrictions and had inconsistent complaints. However, Dr. Goldberg testified that he did not disagree with Dr. Erickson's surgical findings during his April 20, 2012 lumbar surgery, and generally in his practice, Dr. Erickson found that the typical recovery time for his patients who underwent that type of surgery was three to six months. Nevertheless, Dr. Goldberg testified that at his second §12 examination, Petitioner was at MMI for his low back despite it being less than two months after his surgery. Dr. Goldberg further testified that after this type of surgery, he would typically send a patient who had a job description like Petitioner back to work after approximately 12 weeks. However, he testified that he recommended Petitioner return to full duty for his low back in less than two months, because Petitioner had a resolution of radicular pain, even though he still had ongoing complaints of low back pain.

Regarding the cervical spine, Dr. Goldberg also testified that if Petitioner had first reported neck pain in February 2012, it would not have any relationship to his May or August 2011 incidents, because any injury would have manifested itself at the time of those incidents. Furthermore, after reviewing Petitioner's job video, Dr. Goldberg disagreed that it showed repetitive neck extension and twisting that was likely to lead to Petitioner's cervical condition.

When this matter proceeded to hearing, Petitioner testified that his current pain was sometimes stronger than before. Petitioner testified that whenever he helps his wife sweep, his back and neck pain reach higher levels than it did prior to May 2011. Petitioner also experiences back, neck, and leg pain when the weather changes. He takes ibuprofen, Naprosyn, and Aleve to manage his current pain.

II. Conclusions of Law

Following a careful review of the entire record, the Commission modifies the Decision of the Arbitrator to award all reasonable and necessary medical expenses for Petitioner's lumbar spine treatment through the hearing date of May 20, 2019, with the exception of all SSEP testing.

At his first §12 examination on October 12, 2011, Dr. Goldberg found a causal connection between Petitioner's lumbar condition and the May 23, 2011 and August 14, 2011 accidents. Thereafter, at his second §12 examination on June 15, 2012, Dr. Goldberg stated that Petitioner was at MMI for his lumbar spine injury, because his exam findings were nonanatomic and did not correlate with L4-L5 pathology. However, diagnostic tests after Dr. Goldberg's June 15, 2012 examination remained indicative of ongoing lumbar pathology. Specifically, on July 6, 2012, a lumbar MRI found disc pathology combining with facet disease to result in bilateral neural foraminal stenosis at L4-L5 and right neural foraminal stenosis at L5-S1. On July 12, 2012, Dr. Engel indicated that the MRI showed L4-L5 neural foraminal stenosis secondary to a contained L4-L5 disc herniation abutting the right L4 nerve root.

The Commission finds that the MRI findings obtained after Dr. Goldberg had placed Petitioner at MMI objectively show ongoing lumbar pathology. Moreover, Petitioner immediately and consistently complained of lumbar symptoms to his treating doctors following the August 14,

2011 accident. Although he had several prior lumbar injuries and a lumbar surgery, Petitioner had been working regular duty for Respondent from 2003 to May 2011 without missing any work due to back pain. For these reasons, the Commission finds that the current condition of Petitioner's lumbar spine is causally related to the August 14, 2011 accident.

The Commission further notes that Dr. Goldberg did not disagree with Dr. Erickson's surgical findings from Petitioner's L4-L5 hemilaminectomy performed on April 20, 2012. Additionally, Dr. Goldberg testified that the typical recovery time for his patients who underwent that same lumbar surgery was three to six months. With this typical recovery time in mind, the Commission does not find it reasonable for Dr. Goldberg to have placed Petitioner at MMI less than two months after his surgery. Dr. Goldberg further testified that he would typically send a patient back to work approximately 12 weeks after this surgery; however, he opined that Petitioner was at full duty for his low back in less than two months. The Commission is not persuaded by Dr. Goldberg's finding that Petitioner's recovery time was less than the usual minimum recovery time for his patients, especially given that Petitioner had ongoing complaints of lumbar pain and MRI evidence of lumbar pathology.

In finding that the record does not support Dr. Goldberg's MMI determination, the Commission awards all reasonable and necessary medical expenses for Petitioner's lumbar spine only through the hearing date of May 20, 2019 as provided by §8(a) and §8.2 of the Illinois Workers' Compensation Act. However, the Commission specifically denies and excludes from this award any expenses related to Petitioner's SSEP testing. The record does not establish the SSEP testing as reasonable or necessary, given that Dr. Goldberg testified that SSEP testing was not generally accepted among spine surgeons and Dr. Erickson testified that it was not commonly used in orthopedic literature or fellowships. In all other aspects not stated herein, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated February 3, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all reasonable and necessary medical expenses related to Petitioner's lumbar spine condition only incurred from the accident date of August 14, 2011 through the hearing date of May 20, 2019 pursuant to §8(a) and §8.2 of the Act. This award of medical expenses excludes any and all bills related to Petitioner's SSEP testing, which the Commission specifically denies and finds to be not reasonable nor necessary medical treatment.

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 $70,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: **4/21/2021**

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Marc Parker*
Marc Parker

DLS/met
O: 2/18/21
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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC032850
Case Name	RIVERA, CRESCENCIO v. BERRY PLASTIC CORP
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0175
Number of Pages of Decision	11
Decision Issued By	Deborah L. Simpson, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Joseph Zwick

DATE FILED: 4/21/2021

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: PPD	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRESCENCIO RIVERA,

Petitioner,

vs. NO: 11 WC 32850

BERRY PLASTICS CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. Findings of Fact

Petitioner was employed as a set-up man/packer for Respondent. Petitioner alleges that on May 23, 2011, he sustained lumbar and cervical injuries from bending over to pick up lids off the floor at work. The present matter, which covers the May 23, 2011 accident, was consolidated with Petitioner's three other cases, including 11 WC 32848, 11 WC 32849, and 14 WC 31750. The Commission has addressed each of Petitioner's four claims in separate Decisions.

Before starting his employment with Respondent in 2003, Petitioner had prior low back injuries and a low back surgery in 1988. Petitioner thereafter sustained another work accident in 1993 that required physical therapy and a motor vehicle accident in 1998 that required three additional months of physical therapy, after which Petitioner did not seek any other low back treatment until the work accident now at issue. Petitioner continuously worked for Respondent without missing any days due to back pain from 2003 through May 2011.

Following the May 23, 2011 accident, Petitioner presented to Concentra Medical Center on May 24, 2011 with complaints of right-sided low back pain that did not radiate. Lumbar X-rays revealed spurs and degenerative disc disease at L4 to S1, degenerative facet arthropathy at L3

to S1, no spondylolisthesis or spondylolysis, and calcifications suggestive of renal calculi. Dr. Guntippar Pratumngern diagnosed Petitioner with a right sacroiliac sprain and prescribed Aleve, Tylenol, and Biofreeze. Petitioner was then promptly released to regular duty work.

When Petitioner returned to Concentra Medical Center on May 26, 2011, he reported improved symptoms. Dr. Cindy Ross indicated that Petitioner had met all of his treatment goals for his lumbar strain. Dr. Ross continued Petitioner's medication, recommended a home exercise program and heat application, and again released Petitioner to regular duty work. Petitioner testified that he kept working after he was discharged, although his back pain was not gone.

Petitioner continued working at his regular job until he sustained a second work accident on August 14, 2011 from pushing a 70-pound box on a conveyor railing. The August 14, 2011 accident is the subject of the Commission's Decision in 11 WC 32849. On August 15, 2011, Petitioner presented to Concentra Medical Center with complaints of right low back pain radiating into his right leg. Dr. Ross diagnosed Petitioner with lumbar radiculopathy, prescribed ibuprofen and Biofreeze, and provided modified duty restrictions. When he returned on August 17, 2011, Dr. Ross diagnosed Petitioner with a lumbar strain and kept him on modified duty. Petitioner testified that when he returned to work with restrictions after this visit, he noticed ongoing pain in his back, legs, neck, and hands.

Petitioner thereafter sought a second opinion at Marque Medicos on August 19, 2011, at which time he first told Dr. Phillip Gattas that he had right hand pain. Petitioner alleged a third work accident involving hand injuries due to his repetitive work activities manifesting on August 19, 2011. This accident is the subject of the Commission's Decision in 11 WC 32848.

Petitioner's complaints to Dr. Gattas on August 19, 2011 also included bilateral low back pain more pronounced on the left, numbness and tingling down the left lower extremity, and right hand pain with finger swelling, numbness, and tingling primarily in the second and third digits. Lumbar X-rays showed disc space narrowing between L5-S1 and L4-L5, an externally rotated right ilium, degenerative changes, and pelvic/sacral unleveling decreased toward the right with rotation and malposition of vertebral segments. Dr. Gattas diagnosed Petitioner with low back and hand pain. He opined that the conditions were directly related to Petitioner's May 23, 2011 work accident and repetitive trauma culminating on August 19, 2011.

On August 24, 2011, a lumbar MRI further revealed disc bulges with a superimposed right foraminal protrusion at L5-S1, bilateral neural foraminal stenosis at L4-L5, and right neural foraminal stenosis at L5-S1 along with postoperative changes at L4-L5 and sigmoid diverticulosis. Also on August 24, 2011, Petitioner began physical therapy for his low back and right hand.

Upon referral from Dr. Gattas, Petitioner presented to Dr. Andrew Engel of Medicos Pain and Surgical Specialists on September 1, 2011. Dr. Engel started Petitioner on prescription medication management for his herniated lumbar discs. Additionally, Dr. Engel opined that the May 23, 2011 accident was work-related and the direct cause of Petitioner's current pain.

Shortly thereafter, on September 9, 2011, an EMG/NCS showed acute denervation of the left S1 nerve root with no peripheral entrapment or polyneuropathy. On September 19, 2011, Dr.

Engel recommended left L4-L5 epidural steroid injections, which Petitioner underwent on October 5, 2011. When the lumbar injections failed to decrease Petitioner's left-sided pain, Dr. Engel referred Petitioner to Dr. Robert Erickson, a neurosurgeon, on October 12, 2011. Dr. Engel also continued Petitioner's medication management, physical therapy, and off-work restrictions.

Additionally on October 12, 2011, Dr. Edward Goldberg performed a §12 examination at Respondent's request to evaluate the May 23, 2011 and August 14, 2011 accidents. Dr. Goldberg diagnosed Petitioner with an aggravation of L4-L5 and possibly L5-S1 degenerative disc disease. He believed that Petitioner's bilateral leg pain was also from his disc degeneration emanating from L4-L5. Dr. Goldberg opined that Petitioner's condition was work-related to the May 2011 accident with an exacerbation in August 2011. He recommended an additional month of physical therapy and one to two injections, upon completion of which Petitioner would be at MMI. In the interim, he recommended a 10-pound lifting restriction with occasional bending, twisting, and reaching.

Petitioner thereafter returned to work from October 24, 2011 through April 19, 2012. During this time, on October 27, 2011, Dr. Engel recommended left L5-S1 epidural steroid injections, a month of physical therapy, and 10-pound lifting restrictions consistent with Dr. Goldberg's plan. Petitioner underwent the L5-S1 epidural steroid injections on November 9, 2011. On November 15, 2011, Dr. Engel continued Petitioner's medication management and reported that the injections had helped decrease Petitioner's pain.

On December 21, 2011, Petitioner presented to Dr. Erickson of Lake County Neurosurgery with complaints of radicular pain in both legs, worse on the left. Petitioner also reported chronic right hand pain due to repetitive gripping activity at work, as well as some neck stiffness and limited range of motion. Dr. Erickson recommended light duty restrictions and SSEP testing, which was also obtained on December 21, 2011. The SSEP testing of the lower extremities revealed bilateral L5 dermatomal conduction delays, and the SSEP testing of the upper extremities revealed bilateral C7 dermatomal conduction delays.

On January 5, 2012, Dr. Michael Vender performed a §12 examination at Respondent's request regarding Petitioner's right hand. His examination did not concern the lumbar and cervical injuries alleged from the May 23, 2011 accident.

On February 10, 2012, Dr. Erickson noted that there was a correlation between the SSEP testing and the MRI findings of collapse and mild listhesis at L4-L5. He indicated that there were bilateral L5 abnormalities, worse on the left side. As a result, Dr. Erickson recommended a L4-L5 hemilaminectomy beginning on the left side.

A cervical MRI obtained on February 14, 2012 further revealed a C5-C6 posterior disc/osteophyte complex that combined with facet disease to result in central canal and bilateral neural foraminal stenosis. On March 16, 2012, Dr. Erickson noted that the MRI was positive for a C5-C6 herniation with moderate stenosis and mild cord compression. He opined that Petitioner's cervical problem should be corrected first with a C5-C6 anterior cervical discectomy and fusion before proceeding with the recommended lumbar treatment. Dr. Erickson indicated that his recommendations were the result of Petitioner's work-related injury on May 23, 2011.

Petitioner thereafter underwent the recommended L4-L5 hemilaminectomy on April 20, 2012. When Petitioner returned to Dr. Engel on May 1, 2012, his diagnoses were listed as lumbar herniated disc, lumbar radiculopathy, and cervical herniated disc. Dr. Engel indicated that he would treat Petitioner's neck pain after the low back pain had first been fully treated. He continued Petitioner's medication management and off-work restrictions.

On May 11, 2012, Dr. Erickson reported that Petitioner had significant improvement with his right-sided leg pain post-surgery, although he noted increased paresthesia. Dr. Erickson recommended physical therapy, which Petitioner promptly began for his lumbar spine.

On June 15, 2012, Dr. Goldberg performed a second §12 examination of Petitioner's lumbar spine at Respondent's request. In his corresponding report, Dr. Goldberg stated that although he appreciated that Petitioner had a legitimate injury, his examination had nonanatomic findings and did not correlate with L4-L5 pathology. Dr. Goldberg found that Petitioner was at MMI for his lumbar spine and could return to work without lumbar restrictions.

Petitioner then returned to Dr. Engel on July 3, 2012 with complaints of right-sided low back pain shooting to his right calf, bilateral neck pain, and numbness in his first through third fingers. Dr. Engel stopped Petitioner's physical therapy, as he felt Petitioner had plateaued. He then ordered a lumbar MRI, noting that Petitioner had new radiculopathy. The lumbar MRI, which was obtained on July 6, 2012, found disc pathology combining with facet disease to result in bilateral neural foraminal stenosis at L4-L5 and right neural foraminal stenosis at L5-S1. On July 12, 2012, Dr. Engel interpreted the MRI as showing L4-L5 neural foraminal stenosis secondary to a contained L4-L5 disc herniation abutting the right L4 nerve root. On the following day, July 13, 2012, an EMG/NCS yielded normal results with no evidence of acute denervation of the right-sided lumbosacral nerve roots, peripheral entrapment, or polyneuropathy.

On July 25, 2012, Dr. Erickson indicated that Petitioner had mild sensory change within the L5 dermatome and diagnosed him with residual L5 radiculopathy. SSEP testing performed on this date further showed significant evidence of bilateral L5, S1, and C6 dermatomal conduction delays. Dr. Erickson stated that the S1 delay suggested in the SSEP testing was not present intraoperatively, but the SSEP testing nevertheless correlated with Petitioner's MRI as to the C6 abnormality. Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-C6.

On August 9, 2012, Dr. Engel reported that Petitioner's low back pain had improved and his radicular symptoms had resolved, but he still had right-sided low back pain, bilateral neck pain, and numbness in his right second and third fingers. Dr. Engel continued Petitioner's medication management and off-work restrictions.

Petitioner testified that he thereafter returned to work with restrictions for three or four days sometime in August or September 2012. During this time, Petitioner did not perform his regular packing duties and instead worked six hours per day putting tape on the floor. Aside from this brief period of light duty work, Petitioner never went back to work for Respondent.

On September 13, 2012, Petitioner complained to Dr. Engel of worsening low back pain after returning to work. Dr. Engel noted that Petitioner had left greater than right low back pain

that radiated down his left leg, left neck pain, and numbness in his right second and third digits. He stated that Petitioner had also developed left hand numbness to his second and third fingers, since he was only using his left hand at work. Dr. Engel then took Petitioner off work. Petitioner was also kept off work by the orthopedic surgeon treating his hand conditions, Dr. Steven Sclamberg, leading up to and after his right open carpal tunnel release surgery on October 9, 2012.

On November 6, 2012, Petitioner told Dr. Erickson that his neck pain had begun on May 23, 2011 when he lurched upward straining his neck at the same time that he felt the sudden back pain. Dr. Erickson then suggested that the prior SSEP testing may have erroneously noted a C6 abnormality when C7 was the correct abnormal nerve level. He recommended repeat SSEP testing to confirm the presence of C7 radiculopathy. On December 4, 2012, the repeat SSEP testing found bilateral C7 dermatomal conduction delays. On the same day, Dr. Erickson opined that the cause of Petitioner's neck problem and back pain was the original work-related accident of May 23, 2011. In 14 WC 31750, which is addressed by the Commission in a separate Decision, Petitioner also alleged a repetitive trauma injury to his neck with a manifestation date of December 4, 2012.

On December 12, 2012, Dr. Engel kept Petitioner off work for his lumbar and cervical issues, although he had been discharged to full duty for his right hand. Shortly thereafter, on December 14, 2012, Dr. Engel indicated that he had watched a 30-minute job video for Petitioner that showed repetitive work. Dr. Engel then opined that the repetitive nature of this work had helped cause Petitioner's conditions. On January 15, 2013, Dr. Erickson also reviewed the 30-minute job video and opined that it showed repetitive neck extension and twisting that likely led to Petitioner's cervical problem. His diagnosis at that time was C6 radiculopathy relative to a C5-C6 disc herniation. Dr. Erickson continued to recommend surgery and kept Petitioner off work.

At Respondent's request, Dr. Goldberg performed a §12 examination on February 1, 2013 focusing on Petitioner's cervical spine. Dr. Goldberg stated that Petitioner's MRI, which showed disc degeneration and an annular bulge to the right, did not explain why Petitioner had any left-sided symptoms. Additionally, Dr. Goldberg indicated that Petitioner had a positive Tinel's sign at both cubital tunnels that correlated with the numbness, tingling, and pain into his fourth and fifth digits. He did not believe that this finding was coming from a right C5-C6 annular bulge. Instead, Dr. Goldberg opined that it was possible Petitioner had sustained only a cervical strain in the May 23, 2011 accident. Although he found that the cervical treatment had been reasonable and necessary, Dr. Goldberg opined that Petitioner was at MMI for the cervical spine and could return to work without cervical restrictions.

On February 21, 2013, Dr. Engel reviewed Dr. Goldberg's §12 report and found it to be internally inconsistent. Dr. Engel argued that if Petitioner's pre-surgical treatment had been reasonable and necessary as Dr. Goldberg had opined, then the recommended cervical surgery must also be necessary. Dr. Engel continued to recommend cervical surgery with Dr. Erickson and kept Petitioner off work.

Shortly thereafter, on February 26, 2013, Dr. Goldberg authored a §12 addendum stating that he had interpreted Petitioner's cervical MRI to show mild disc degeneration without any herniation or stenosis. He further opined that Petitioner's disc bulge would not have been caused by his work accident.

On March 18, 2013, Dr. Erickson reported that Petitioner's lumbar surgery had significantly helped his low back pain, but his neck pain was now the chief concern. Dr. Erickson further stated that Dr. Goldberg had oversimplified Petitioner's C5-C6 herniation by finding that it did not explain his left-sided pain since it was central and right in location. Instead, he stated that the herniation was associated with mild cord compression and it was well-known that decussation or crossing of anterior spinothalamic tracts could cause contralateral pain. Dr. Erickson opined that Petitioner's herniation was best characterized as central, and as such, Dr. Goldberg's criticism was invalid.

At follow-up visits in April and May 2013, Dr. Engel kept Petitioner off work as they awaited approval for the cervical surgery. On July 25, 2013, Dr. Engel continued Petitioner's medication management and ordered a left L4 epidural steroid injection, which was subsequently administered on August 8, 2013. When Petitioner returned on August 19, 2013, Dr. Engel reported that his left-sided low back pain had improved post-injection. Dr. Engel noted that Petitioner's residual lumbar pain would now be addressed after his cervical pain had been treated with the recommended surgery. At this visit, as well as the follow-up visit on October 8, 2013, Dr. Engel kept Petitioner off work and prescribed Ultram.

On November 19, 2013, Petitioner saw Dr. Fernando Perez, a chiropractor, at Marque Medicos. Dr. Perez indicated that Petitioner was discontinuing his follow-up consultations with Dr. Engel, because Dr. Engel was no longer affiliated with Medicos Pain and Surgical Specialists.

On December 18, 2013, Petitioner saw Dr. Leonard Kranzler at Northside Neurosurgery for a neurosurgical examination on behalf of Dr. Erickson. Dr. Kranzler stated that on May 23, 2011, Petitioner was lifting heavy objects when he felt low back pain and developed right hand pain with numbness, tingling, and weakness in his second and third fingers. Petitioner indicated that his pain was now in his neck radiating down both shoulders with numbness and tingling in his left hand, ring finger, and small finger. Dr. Kranzler referred Petitioner to pain management.

Petitioner presented to Dr. Sue Harsoor, a pain management doctor, on January 24, 2014. Dr. Harsoor diagnosed Petitioner with cervical and lumbosacral radiculopathy, refilled his tramadol prescription, and kept Petitioner off work. Shortly thereafter, on February 3, 2014, Respondent sent Petitioner a letter stating that it was permanently closing its facility, and as such, Petitioner's last date of employment would fall during a 14-day period beginning on April 7, 2014.

On April 9, 2014, Dr. Erickson reported that Petitioner's low back pain had improved as a result of his lumbar surgery, but his ongoing neck pain had persisted after many months. Petitioner also continued to complain of painful paresthesia radiating to the fourth and fifth fingers on his left hand. Dr. Erickson suggested that Petitioner pursue injection treatment until his cervical surgery was approved. On October 8, 2014, Dr. Erickson obtained repeat SSEP testing that yielded virtually identical results to the 2012 test with a slight progression on the left side and standard deviations at the C6 nerves. Dr. Erickson continued to recommend a C5-C6 anterior cervical discectomy and fusion, which he opined was a consequence of Petitioner's original work injury.

When Petitioner returned to Dr. Erickson on June 30, 2015, he complained of low back

pain radiating to his left toes and neck pain radiating to his left fourth and fifth fingers. Dr. Erickson found that Petitioner's neurological examination was reassuring with no dermatomal sensory loss or clear atrophy. Nevertheless, Petitioner had diminished grip strength in the left hand, which Dr. Erickson opined was likely due to changes following his C5-C6 injury and disc herniation. Dr. Erickson's diagnoses at this time were lumbar and cervical spondylosis.

On August 5, 2015, Petitioner underwent an FCE that placed his capabilities at the light physical demand level and his position at the medium physical demand level. However, the evaluator stated that the FCE results were conditionally valid and represented Petitioner's perceived capabilities, even though he could physically do more. When Petitioner returned to Dr. Erickson on August 8, 2015, Dr. Erickson found that Petitioner was capable of lifting 15 pounds occasionally and 10 pounds frequently. Additionally, Dr. Erickson stated that Petitioner had C5-C6 problems following a work injury in September 2012 where a 40-pound box fell onto the left side of his head and shoulder.

On October 27, 2015, Dr. Erickson again referenced an alleged work injury that occurred after a box fell onto Petitioner's head. This treatment note listed the incident as occurring in September 2015, whereas the August 8, 2015 note said it happened in 2012. Dr. Erickson also indicated that he expected Petitioner's FCE restrictions to be permanent based upon the chronicity of his symptoms. He then put his plans to obtain a new cervical MRI on hold, since Petitioner's neck pain had receded, and prescribed tramadol and over-the-counter medication.

Petitioner testified that after he was discharged by Dr. Erickson in October 2015, he attempted to find work within his restrictions. Petitioner never went back to work for Respondent, as Respondent's facility permanently closed down on June 21, 2014. Petitioner eventually found work with ABM Janitorial in September 2016. Petitioner worked 32 hours per week at ABM Janitorial cleaning desks, sweeping, and vacuuming until September or October 2017. Petitioner testified that he then retired due to the pain in his legs, back, and neck. Petitioner has not looked for any other job since he stopped working around October 2017.

Petitioner returned to Dr. Erickson a final time on September 26, 2017 and reported difficulty after returning to work with a 20-pound lifting restriction. On examination, Petitioner complained of painful bending with flexion limited more than extension for the lumbar spine and paresthesia radiating to both feet with right-sided predominance. There was no dermatomal sensory deficit. Dr. Erickson recommended a 10-pound lifting restriction as well as no excessive bending, stooping, or lifting in a part-time capacity. Dr. Erickson indicated that further surgery was not being contemplated at that time, and instead, Petitioner was to continue treating with tramadol, Aleve, and ibuprofen. Petitioner was then instructed to return on an as-needed basis.

Prior to proceeding to hearing, the parties deposed Dr. Erickson, Dr. Goldberg, Dr. Sclamberg, and Dr. Vender. Both Dr. Sclamberg and Dr. Vender provided opinions concerning Petitioner's right hand condition, which is the subject of 11 WC 32848, and not Petitioner's low back or cervical conditions. As relevant to Petitioner's present claim, the parties deposed Dr. Erickson, Petitioner's treating doctor, on November 15, 2016 and Dr. Goldberg, the §12 examiner, on August 14, 2017.

Dr. Erickson testified that his diagnosis for Petitioner's lumbar spine was radiculopathy secondary to collapse and mild listhesis at L4-L5. He opined that given Petitioner's history of productive work activity for years after his pre-accident lumbar surgery, Petitioner's current condition was related to the May 23, 2011 and August 14, 2011 accidents. Dr. Erickson's understanding was that Petitioner was working successfully from 1998 through 2011 before his accidents. As such, he regarded the two work accidents as the probable cause of Petitioner's lumbar problems. Dr. Erickson testified that when he saw Petitioner on October 27, 2015, Petitioner still had back pain, albeit improved, and had restrictions that were likely permanent. He indicated that Petitioner was at MMI for his back at that time, but he made no determination regarding his grip strength or neck.

Regarding the cervical spine, Dr. Erickson's diagnosis was a significant disc problem at C5-C6 that was probably causative of Petitioner's upper extremity symptoms. Dr. Erickson testified that when he reviewed Petitioner's job video, it showed repetitive work above shoulder-height with neck extension. He testified that the repetitive activity depicted on the video was a possible cause of Petitioner's disc herniation. Dr. Erickson opined that Petitioner's cervical condition was a combination of acute and repetitive incidents, where repetitive activity weakened the disc and the herniation was perceived as an acute painful episode. He testified that Petitioner's cervical condition was causally related to his work activity based on the history Petitioner provided of a sudden onset of neck pain that was associated with repetitive twisting and lifting activity.

On the other hand, Dr. Goldberg testified that at the time of his second §12 examination on June 15, 2012, Petitioner was at MMI for his low back, could return to work without lumbar restrictions, and had inconsistent complaints. He testified that he recommended Petitioner return to full duty for his low back in less than two months post-surgery, because Petitioner had a resolution of radicular pain, even though he still had ongoing complaints of low back pain. Regarding the cervical spine, Dr. Goldberg further testified that if Petitioner had first reported neck pain in February 2012, it would not have any relationship to his May or August 2011 accidents, because any injury would have manifested itself at the time of those incidents. Furthermore, after reviewing Petitioner's job video, Dr. Goldberg disagreed that it showed repetitive neck extension and twisting that was likely to lead to Petitioner's cervical condition.

When this matter proceeded to hearing, Petitioner testified that his current pain was sometimes stronger than before. Petitioner testified that whenever he helps his wife sweep, his back and neck pain reach higher levels than it did prior to May 2011. Petitioner also experiences back, neck, and leg pain when the weather changes. He takes ibuprofen, Naprosyn, and Aleve to manage his current pain.

II. Conclusions of Law

Following a careful review of the entire record, the Commission modifies the Decision of the Arbitrator to find that Petitioner sustained a loss of 2.5% MAW for his lumbar spine injury. Since the accident date falls before September 1, 2011, the Commission is not required to apply the §8.1b statutory factors when assessing Petitioner's award of permanent partial disability. Nevertheless, for analysis purposes, the Commission has considered the §8.1b enumerated criteria, including: (i) the reported level of impairment pursuant to (a) [AMA "Guides to Evaluation of

Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability as corroborated by treating medical records. 820 ILCS 305/8.1b(b).

Regarding criterion (i), no AMA impairment rating was provided in this case. As such, the Commission assigns no weight to this factor.

Regarding criterion (ii), Petitioner was a set-up man/packer on the accident date. After the May 23, 2011 accident, Petitioner was promptly released to full duty work on May 24, 2011 and May 26, 2011 by his treating doctors. Petitioner continued to work at his regular job after he was discharged on May 26, 2011 until his second work accident occurred on August 14, 2011.

Following Petitioner's subsequent work accidents, a conditionally valid FCE placed his capabilities at the light physical demand level on August 5, 2015. Petitioner was then given permanent restrictions pursuant to the FCE by Dr. Erickson. Petitioner testified that after he was discharged with restrictions in October 2015, he tried to find work elsewhere, because Respondent had permanently closed its facility. Petitioner eventually found work with ABM Janitorial in September 2016. In this position, Petitioner worked 32 hours per week cleaning desks, sweeping, and vacuuming. However, Petitioner testified that he only worked for ABM Janitorial until September or October 2017, because he had ongoing pain in his back, neck, and legs. Petitioner has since retired. Because Petitioner was discharged to his full duty position in between his May 2011 and August 2011 accidents, the Commission assigns moderate weight to this factor.

Regarding criterion (iii), Petitioner was 57 years old on the accident date. There was no testimony as to how Petitioner's age affected his disability, and Petitioner ultimately made the decision to retire and remove himself from the workforce. As such, the Commission assigns some weight to this factor.

Regarding criterion (iv), Petitioner was discharged and released to his regular duty job on May 26, 2011. Petitioner thereafter continued to work in his full duty position until his second accident on August 14, 2011 accident. As such, the Commission does not attribute a loss of future earning capacity to the May 23, 2011 accident. Even though Petitioner's W-2s from ABM Janitorial show decreased earnings, this occurred after Petitioner's sustained the low back aggravation on August 14, 2011, which is covered under 11 WC 32849. The Commission thus assigns some weight to this factor.

Regarding criterion (v), Petitioner treated conservatively and minimally for his low back injury in between his May 23, 2011 and August 14, 2011 accidents. Following the May 23, 2011 accident, Petitioner was discharged from Concentra Medical Center for his resolved lumbar strain on May 26, 2011 after only two treatment visits. At that time, Dr. Ross indicated that Petitioner had met all of his treatment goals. After being released, Petitioner continued working full duty up until the August 14, 2011 accident. Although he noted lingering pain, Petitioner did not seek further treatment in between May 26, 2011 and August 14, 2011.

Petitioner's lumbar condition was significantly aggravated after his second work accident on August 14, 2011, as he thereafter required a L4-L5 hemilaminectomy, multiple injections,

ongoing medication, physical therapy, and permanent restrictions. Nevertheless, Petitioner's current condition and ongoing pain complaints were determined to be causally related, in part, to the May 23, 2011 accident by Dr. Erickson. At the time of the hearing, Petitioner continues to experience increased back pain whenever he helps his wife sweep or the weather changes. To manage his persisting pain, Petitioner takes ibuprofen, Naprosyn, and Aleve.

Upon consideration of these factors, the Commission notes that Petitioner's decreased wages and permanent restrictions are more appropriately attributed to his August 14, 2011 accident. Nevertheless, Petitioner required conservative care and prescription medication to treat his lumbar sprain from the May 23, 2011 accident and testified that his back pain persisted after he was discharged to his full duty job on May 26, 2011. As such, the Commission finds that Petitioner sustained a loss of 2.5% MAW for the lumbar injury he sustained in the May 23, 2011 accident. The Commission modifies the Decision of the Arbitrator accordingly, and in all other aspects not stated herein, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated January 23, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $344.79 per week for a period of 12.5 weeks, as provided in §8(d)2 of the Act, as the injuries sustained to Petitioner's lumbar spine caused a loss of 2.5% MAW.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,500.00. 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 the Circuit Court.

DATED: **4/21/2021**

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Marc Parker*
Marc Parker

DLS/met
O: 2/18/21
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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC031750
Case Name	RIVERA, CRESCENCIO v. BERRY PLASTIC CORP
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0176
Number of Pages of Decision	2
Decision Issued By	Deborah L. Simpson, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Martin Deely

DATE FILED: 4/21/2021

14WC31750

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

CRESCENCIO RIVERA,
Petitioner,

vs. NO: 14 WC 31750

BERRY PLASTICS CORP.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 23, 2020, is hereby affirmed and adopted.

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

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

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: **4/21/2021**

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Marc Parker*
Marc Parker

DLS/rm
O: 2/18/21
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC043849
Case Name	CASEY, HAL M v. ILLINOIS STATE UNIVERSITY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0177
Number of Pages of Decision	10
Decision Issued By	Deborah J. Baker, Commissioner

Petitioner Attorney	RICHARD JOHNSON
Respondent Attorney	LOUIS LAUGGES, AAG

DATE FILED: 4/21/2021

/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

HAL M. CASEY,

Petitioner,

vs. NO: 12 WC 43849

ILLINOIS STATE UNIVERSITY - STATE OF ILLINOIS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, corrects 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 parties stipulated Petitioner was entitled to 229 weeks of Temporary Total Disability benefits and 131 2/7 weeks of maintenance benefits, and further stipulated Respondent was entitled to a credit of $158,918.43 for benefits paid. Arbitrator's Exhibit 2. The Arbitrator's decision awarded Respondent the credit but did not award Petitioner the associated benefits. Therefore, the Commission corrects the decision to award Temporary Total Disability benefits for the stipulated period of March 29, 2012 through August 17, 2016 as well as maintenance benefits for the stipulated period of August 18, 2016 through February 29, 2019.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 2, 2020, as corrected above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $441.09 per week for a period of 229 weeks, representing March 29, 2012 through August 17, 2016, that being the stipulated 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 in the amount of $441.09 per week for a period of 131 2/7 weeks, representing the stipulated period of August 18, 2016 through February 29, 2019, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit of $158,918.43 for temporary disability payments already made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay any outstanding, related, reasonable and necessary medical expenses, including those from Illinois Physicians Network (Dr. Alzoobi) in the amount of $7,756.50 and Allied Health Group (Dr. Dickhut) in the amount of $9,340.00, as provided in §8(a) and subject to §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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent total disability benefits in the amount of $483.36 per week for life, that being the statutory minimum permanent total disability rate for Petitioner's accident date, commencing on March 1, 2019, as provided in §8(f) of the Act. 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: **4/21/2021**

/s/ *Deborah J. Baker*

DJB/mck
O: 4/7/21
043

/s/ *Stephen Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0177
NOTICE OF ARBITRATOR DECISION

CASEY, HAL M
Employee/Petitioner

Case# **12WC043849**
12WC043848

ILLINOIS STATE UNIVERSITY - STATE OF ILLINOIS
Employer/Respondent

On 9/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0499 CMS RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
801 S 7TH ST 8M
SPRINGFIELD, IL 62794

0988 ASSISTANT ATTORNEY GENERAL
LOUIS LAUGGES
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

SEP 2 - 2020

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

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

- [ ] 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
NATURE AND EXTENT ONLY

Hal M. Casey
Employee/Petitioner

v.

Illinois State University - State of Illinois
Employer/Respondent

Case # **12** WC **43849**

Consolidated cases: **12 WC 43848**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **08/24/2020**. By stipulation, the parties agree:

On the date of accident, **01/26/2012**, 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 $**34,405.28**, and the average weekly wage was $**661.64**.

At the time of injury, Petitioner was **55** years of age, ***married*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent: **SEE ORDER ATTACHED HERETO**

Respondent shall be given a credit of $**158,918.43 for TTD and maintenance benefits based on benefits due for 360-2/7 weeks, payable at $441.09 per week.**

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

ORDER

Respondent shall pay Petitioner permanent and total disability benefits of $**483.36**/week for life, commencing **March 1, 2019**, as provided in Section 8(f) of the Act.

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

Respondent shall pay any outstanding, related, reasonable and necessary medical expenses, including those from Illinois Physician's Network (Dr. Alzoobi) in the amount of $7,756.50 and Allied Health Group (Dr. Dickhut) in the amount of $9,340.00, subject to the Medical Fee Schedule. Respondent shall receive a credit for any medical expenses it has already paid and shall hold Petitioner harmless under Section 8(j) of the Workers' Compensation Act for any amounts paid and/or adjusted by insurance.

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

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

Signature of Arbitrator Gerald Granada

9/1/20
Date

SEP 2 - 2020

FINDINGS OF FACT

This case involves Petitioner Hal Casey, who was injured while working for Respondent Illinois State University / State of Illinois on October 7, 2010 (12 WC 43848) and on January 26, 2012 (12 WC 43849). Petitioner has filed separate Applications for Adjustment of Claim for all of these accidents, and all the claims have been consolidated. Although all these claims were heard together, this decision is on Petitioner's January 26, 2012 claim, in which the primary issue in dispute is the nature and extent of Petitioner's injuries – specifically, whether Petitioner is permanently and totally disabled as a result of this accident.

Petitioner testified that on January 26, 2012, he was lifting up folding tables when he noticed something happened to his back. He worked for another two months after this incident and continued to experience increasing low back pain for which he sought medical care at McLean County Orthopedics beginning on March 26, 2012. Petitioner related a history of a low back injury on October 1, 2009 and more recently the accidental injury of January 2012. He was initially diagnosed with acute low back pain, left leg pain, radiculitis in the left lower extremity, and was taken off work at that time. (PX2). He underwent epidural steroid injections on April 24, 2012 and May 18, 2012. In an office visit of June 5, 2012 Dr. Carmichael stated that the injections did not seem to be working and that Petitioner may be a surgical candidate, opining a recent EMG showed a left L5 radiculopathy. (PX2, OV 6/5/2012). At Respondent's request, Dr. Timothy Van Fleet evaluated Petitioner on August 29, 2012. Dr. Van Fleet opined that Petitioner required bilateral laminotomies at L4-5 and L5-S1 and that there was a causal connection between the work accident and the need for the surgery. (RX2).

Petitioner came under the care and treatment of Dr. Nardone, who evaluated Petitioner for a neck problem and noted that Petitioner complained of worsening shoulder and neck stiffness with weakness into both hands over the prior year. Petitioner underwent a C3-C4 anterior decompression and fusion as well as removal of a large osteophytes that was not related to his work accident. (PX3).

On January 11, 2013 Dr. Nardone performed an L4-L5 decompression surgery on Petitioner. Dr. Nardone referred Petitioner to Dr. Kolb for ongoing left shoulder and arm pain. (PX3). Petitioner testified that subsequent to this surgical procedure he continued to have low back and leg pain. He was seen by Dr. Templin in May, 2013 who referred him to Dr. Alzoobi for injection therapy. Petitioner had an epidural steroid injection on August 20, 2013, a medial branch block on September 24, 2013 and a radiofrequency ablation on October 1, 2013. (PX4).

On March 20, 2014, Dr. Frank Phillips evaluated Petitioner pursuant to Section 12. Dr. Phillips opined Petitioner's work injury of 2012 was a "proximate cause" in the need for his subsequent medical care and at the time of this evaluation Petitioner was doing poorly with axial back pain and some bilateral radicular symptoms. Dr. Phillips recommended a discogram which if confirmatory would require surgery. In his addendum dated August 26, 2014 Dr. Phillips reviewed the discogram study performed May 8, 2014 noting that an L3-4 radial tear was noted and at L4-5 contrast material extended to the outer annulus and anterior annular fissure was noted. Surgery was approved and undertaken on January 28, 2015 by Dr. Templin, consisting of fusion with hardware. (RX3, PX3). Petitioner testified post operatively he experienced increasing symptoms and that Dr. Templin referred him to Dr. Sharma who performed a branch block on May 12, 2016, an injection over a screw on June 27, 2016, and ultimately Dr. Sharma recommended a spinal cord stimulator trial. (PX6).

On August 18, 2016, Dr. Phillips conducted another Section 12 examination of Petitioner. Dr. Phillips reviewed the March 28, 2016 CT results confirming an L4-5 and L5-S1 anterior lumbar interbody fusion with

anterior plate instrumentation. Some lucency around the S1 screw on the right was noted but no migration. Dr. Phillips opined that the lumbar fusion was well healed with residual low back pain and that Petitioner had plateaued with conservative care and reached maximum medical improvement. He diagnosed Mr. Casey with a failed back surgery syndrome, noted that prognosis for resumption of normal activities is poor and that a functional capacity evaluation should be done to determine more precise restrictions. (RX4).

On October 19, 2016, Petitioner underwent a functional capacity examination at Carle Clinic. Limitations were noted with respect to walking, stairclimbing, kneeling, forward bend, standing, lifting, and carrying. Petitioner was placed at a light physical demand level lifting 15 to 20 pounds but would be unable to safely perform mopping due to repetition, unable to safely perform changing of garbage due to weight requirements as well as other limitations noted in the FCE grid. (PX7).

Petitioner testified that he began looking for work, completing job logs. Petitioner testified he applied for more than 525 jobs without any offer of employment. (PX8).

Petitioner testified he had left high school in his sophomore year to begin working. His work experience prior to working for Illinois State University was as a roofer for approximately 17 years.

On June 13, 2017 Steven Blumenthal, a certified rehabilitation counselor, evaluated Petitioner. Mr. Blumenthal noted that Petitioner is a literate reader of English, but a slow reader and unable to complete the reading comprehension section on a timed basis. He also noted that Petitioner has a high average reading vocabulary but a below average reading comprehension in comparison to students entering community college. He further indicated that Petitioner would have more difficulty reading and comprehending textual materials that would be encountered in a technical school or community college-based learning environment. (RX5). Additionally, he noted that Petitioner's spelling was below average - falling in the 16th percentile with reading comprehension in the 12th percentile; and he had average math computational ability in comparison to his age peers. Petitioner's BETA IQ was 80 which is in the 9th percentile and Petitioner demonstrated a low average non-verbal reasoning ability. (RX5).

Mr. Blumenthal opined that given the very specific work restrictions placed on Petitioner, a traditional transferable skills and aptitude analysis could not be completed and there would be no way of accurately entering the work restrictions into a software program to complete the analysis. Instead he recommended a Labor Market Survey to specifically compare Petitioner's documented physical abilities and work release in comparison taking into account his past work history, education and vocational testing results. (RX5).

Mr. Blumenthal identified two part-time positions that paid $10.00 an hour between 15 to 20 hours of work. He opined Petitioner is unable to return to work performing any job he has done in the past and that if he were to find work it would not exceed earnings of $150.00 to $200.00 per week. (RX5). Petitioner testified that he applied for the part-time jobs identified by Mr. Blumenthal. The jobs were approximately 45 miles from his home and while he interviewed for the positions, neither was offered to him.

A vocational case manager from Creative Case Management prepared a "blind transferrable skills analysis/labor market survey" dated October 24, 2017, and opined that the outlook for Petitioner to become gainfully employed was guarded. Although he had transferrable skills from previous employment, his physical restrictions prevent full use of those skills in the current labor market, he lacked familiarity with computers and contemporary office programs, and is functionally unable to perform at a competitive level. That report also

noted that Petitioner's age would be a factor in his ability to adjust to other work. On May 5, 2018, Respondent requested Creative Case Management undertake vocational rehabilitation. Job titles to be pursued based on the client's medical capabilities, training and experience were determined to be: 1) customer service, 2) telephone solicitor and 3) front desk. (RX6). On June 28, 2018 (Vocational Report #3) the vocational case manager indicated it was her opinion Petitioner was non-compliant with vocational services as Petitioner was provided with 30 job contacts and he documented only 28 employer job contacts. There was a further issue that he had not followed up with some job leads as previously recommended. Respondent terminated vocational services on February 20, 2019. Petitioner testified that he stopped looking for work by the end of February, 2019.

Petitioner testified that he never refused to make any job search and of those he did not seek out did not fit within his physical restrictions. He still has complaints of intense pain that limit his everyday activities.

Respondent called as its witness, Jana Range, a vocational case manager with Creative Case Management. She testified that Kathy Weber, the vocational case manager assigned to Petitioner was no longer employed with the agency. Ms. Range never prepared a vocational report in connection with Petitioner's vocational rehabilitation. She testified that TriStar (Respondent's third party administrator) sets the standard and people are either 100% compliant or non-compliant. She further testified that she did not review Mr. Blumenthal's testing of Petitioner. She rendered no opinion that Petitioner could work, nor did she identify any jobs for which he was qualified to work.

CONCLUSIONS OF LAW REGARDING THE ISSUE OF NATURE AND EXTENT

With regard to the issue of nature and extent, the Arbitrator concludes that based on the Petitioner's medical evidence and his unrebutted testimony regarding his medical treatment, complaints and physical limitations following his work accident, the Petitioner's injuries stemming from his January 26, 2012 accident have resulted in him becoming permanently totally disabled under the "odd lot" category. A person is considered totally disabled when they are unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonable stable market for them A.M.T.C. of Illinois, Inc. v. Industrial Comm'n, 397 N.E.2d 804, 806 (1979). If an employee's disability is of a limited nature such that they are not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the employee has the burden of establishing that they fall into the "odd-lot" category, one who, though not altogether incapacitated from work, is so handicapped that they will not be employed regularly in any well-known branch of the labor market. Ceco Corp. v. Industrial Com., 447 N.E.2d 842, 845-846 (1983). There are two ways an employee can ordinarily satisfy their burden of proving that they fit into the "odd-lot" category: (1) by showing a diligent but unsuccessful job search, or (2) by demonstrating that because of their age, training, education, experience, and condition, they are unable to engage in stable and continuous employment. Westin Hotel v. Industrial Comm'n, 865 N.E.2d 342, 357 (1st Dist. 2007). Once the employee has initially established the unavailability of employment to a person in their circumstances, the burden then shifts to the employer to show that suitable work is regularly and continuously available to the employee. Valley Mould & Iron Co. v. Industrial Com., 419 N.E.2d 1159, 1163 (1981). Here, the Petitioner made a diligent but unsuccessful job search. Furthermore, the opinions of the vocational counselors, and Petitioner's age, education, past work experience and physical restrictions all establish Petitioner's inability to engage in stable and continuous employment. Respondent did not provide any evidence to show that suitable work is regularly and continuously available to Petitioner. Based on the evidence, the Arbitrator concludes that the Petitioner falls into the "odd lot" category of permanent total disability.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC008104
Case Name	PHILLIPS, LONNIE v. ILLINOIS STATE TOLL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0178
Number of Pages of Decision	27
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Steven Scarlati
Respondent Attorney	Robert Delaney

DATE FILED: 4/21/2021

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

LONNIE PHILLIPS,

Petitioner,

vs. NO: 17 WC 8104

ILLINOIS STATE TOLL
HIGHWAY AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 30, 2020 is hereby affirmed and adopted.

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

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

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: 4/21/2021
o: 4/15/21
BNF/kcb
045

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Christopher A. Harris*
Christopher A. Harris

/s/*Marc Parker*
Marc Parker

21IWCC0178

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

PHILLIPS, LONNIE
Employee/Petitioner

Case# **17WC008104**

17WC008105
17WC035924

ILLINOIS STATE TOLL HWY AUTHORITY
Employer/Respondent

On 4/30/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0312 BOUDREAU NISIVACO LLC
ALAN BOUDREAU
120 N LASALLE ST SUITE 1250
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT F DELANEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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

1024 IL STATE TOLL HIGHWAY AUTHY
2700 OGDEN AVENUE
WORKERS COMPENSATION DEPT
DOWNERS GROVE, IL 60515

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

APR 30 2020

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

21IWCC0178

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)

LONNIE PHILLIPS
Employee/Petitioner

v.

ILLINOIS STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

Case # **17** WC **08104**

Consolidated cases: **17 WC 08105 & 17 WC 35924**

An *Application for Adjustment 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 **October 19, 2018, October 11, 2019 and November 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. ☒ 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, **February 27, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***no longer is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**Unknown**; the average weekly wage was $**1,270.80**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner's low back condition on February 27, 2017 was causally related to the February 27, 2017 accident, but that the accident resulted in a temporary aggravation of a longstanding preexisting lumbar condition.

Respondent shall pay reasonable and necessary medical services of Advocate Occupational Medicine on February 27, 2017, as provided in Sections 8(a) and 8.2 of the Act, if this expense remains unpaid. Respondent is entitled to credit for payment of this bill.

Petitioner's claims for temporary total disability and prospective medical benefits are denied.

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

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

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

Phillips v. Illinois State Toll Hwy Auth., 17 WC 008104

Signature of Arbitrator

April 20, 2020
Date

APR 3 0 2020

STATEMENT OF FACTS

Petitioner testified he has been employed by Respondent as an Equipment Operator Laborer (EOL). Respondent's main office is in Downers Grove, but they have garages scattered throughout the system, and Petitioner's was located at I-294 and Cermak Road, Maintenance Garage 2, in 2017. An 11-year employee, Petitioner testified he is left hand dominant, and that he has lived in Lisle, Illinois since 2016. The job involves a variety of road-related activities, including concrete / pavement demolition and repair, guardrail repair, cleaning up after vehicle accidents, plowing snow, fixing drainage appurtenances, cutting grass, driving tractors, graffiti removal, cutting trees and brush and driving a street sweeper. Physically, Petitioner testified he would lift from things ranging from a two-pound hammer to a 90-pound bag of cement mix. He indicated there are things that are heavier that he has not personally weighed, such as a 25' piece of guard rail, a tow behind water pump, snowplow blades, spreader boxes for salt, etc. He testified he also has to shovel asphalt and concrete sand.

Petitioner testified he worked 40 hours per week dayshift from 7 a.m. to 3 p.m., Saturday through Wednesdays with Thursday and Fridays off, in early 2017. He would also get overtime, particularly with snow plowing or accident clean up. He would generally work the roads between O'Hare Airport and I-55, which he indicated has lots of interchanges and accidents. Overtime is mandatory in winter, and he estimated he would average 200 hours of overtime during the winter. He would drive a variety of vehicles, anything from pickup trucks to dump/plow trucks, sometimes with large plows. Petitioner testified that his duties would change day to day. He would go to the maintenance garage in the morning to attend a daily meeting and to get his assignment for the day. He and his co-workers would generally work in teams. Petitioner testified his main job was setting up lane closures, along with performing repairs. Petitioner testified that the truck is cramped to drive and can be very bouncy with snow plowing, especially if you do not know the road areas where the plow might catch. In order to cut trees or bushes he would use chain saws, hedge trimmers, lawnmowers and weed whippers. Normally he takes breaks during his shifts, but he noted it is hard to take breaks during snow plowing.

Petitioner testified that weekend assignments are given on Fridays, as there are no weekend meetings, and he had been assigned to work on 2/5/17, a weekend date (and the subject of case 17 WC 35924), cutting trees and brush from sound/noise walls along I-294. He testified he was working with co-workers Erv Quinones and Greg Arredia and he was operating an 18" chain saw. He testified that he did this work for .5 to 1 mile near the Ogden and Hinsdale Oasis Northbound wall from approximately 8 a.m. to 10 a.m. He testified he became uncomfortable from carrying the 20-pound saw while hunched over and had severe pain in his back bilaterally at the belt line when he tried to stand up straight. He let his co-workers know he was going to the truck to rest, and when they came to the truck, he indicated he was having pain and was walking like another co-worker who walks hunched over. Petitioner testified he has had prior low back pain but had no such pain when he reported to work that day. When he didn't improve during lunch break, he called his boss, Phil Cassman, and told him what happened. Petitioner testified that Cassman advised him to contact Corvel to make a report and to take it easy and to wash trucks that day. Petitioner testified that he did not seek treatment. He testified he didn't complete an accident report for Respondent until the following Monday (Px2), because supervisors aren't in the office/garage on weekends and he "didn't think it was too serious." Petitioner spoke to either Cassman or Don

Ryan, the other supervisor at the garage, on 2/6/17. When he spoke to Corvel, Petitioner didn't indicate he needed treatment, and the Corvel nurse advised him to use ibuprofen and ice for a couple days and to call back to obtain treatment if he didn't improve. He continued to work through the following Wednesday but didn't improve so he again contacted Corvel that Thursday. Treatment wasn't approved at Petitioner's choice of the Back Institute, and he testified he was only approved to see Dr. Bicek.

Petitioner saw Dr. Bicek on 2/14/17 and reported the following history: "States he was using a chainsaw cutting trees along the tollway at work on 5 February for about hour to 2. He then started having low back pain. He was told to take it easy and wash the trucks the rest of the day. He continued to go to work. Wednesday 3 days later he had more lower back pain. This has persisted. It's worse when he wakes up maybe 5/10. It gets better 2-3/10 during the day." He denied leg pain, numbness or weakness. Petitioner indicated he did not want to be on light duty at work. Acute low back pain without sciatica was diagnosed and he was prescribed Naproxen and advised to rest. The Arbitrator did not note any statements regarding Petitioner's work status. (Px9A). Petitioner testified that Dr. Bicek prescribed physical therapy and home exercises, that therapy wasn't approved and that he didn't return to see Dr. Bicek. He continued to work full duty, acknowledging he requested a release to return to full duty.

On 2/27/17 (the subject of case number 17 WC 08104), Petitioner testified he was assigned to operate a street sweeper. While driving back to the garage to dump his full load, at highway speed, he hit a pothole or defect in the road, lifting him off the seat and striking his head on the roof. He testified he felt back pain at that time and reported the incident to either Cassman or Ryan. He again was advised to contact Corvel, which he did, and was referred to the company clinic.

At Advocate Occupational Health on 2/27/17, Dr. Hyre recorded that Petitioner was driving a street sweeper that day, hit a large pothole and came down hard on a rigid seat, injuring his lower back. There were no neurologic symptoms. Petitioner reported a prior history of herniated discs. Dr. Hyre prescribed a Medrol dosepak and released Petitioner to return to regular work duties "Per pt request", noting Petitioner was "refusing any work restrictions." The discharge states: "Follow up with Illinois Back Institute per your request." (Px10). Petitioner testified he believed he and Dr. Hyre discussed his job duties and what type of work he was going to be returning to, as well as that he had a preexisting back condition going back to 2012. He again acknowledged he didn't want to be off work and asked her to return him to regular duty, which he did the next day, 2/28/17.

Petitioner testified he was feeling "about 90%" at work on 2/28/17. He was assigned that day to use an air hammer to break out collapsed drains on the side of the road, remove the concrete and then pour new concrete. Concrete preparation involves mixing a 90-pound bag of cement mix, 15 shovels of gravel and 15 shovels of sand. He estimated he had to move about 5 tons of broken concrete that day, and that he "also" bumped into the truck a couple of times, injuring his left elbow. He recalled using approximately 10 bags of concrete. Two coworkers were using the shovels. He also was asked to help two other workers to remove broken up concrete, testifying they filled the back of a pick-up truck about 3' above the truck sides. He testified that towards the end of the shift he bumped his left elbow. Believing he hit his funny bone, he shook it off and went back to work. When he later removed his long sleeves, he noticed that his elbow was swollen. He had a pre-planned day off the next day and his regularly scheduled two off days off after that. He called Corvel and was sent back to Advocate Occupational Health.

Petitioner returned to Dr. Hyre on 2/28/17 (4:59 p.m.), this time reporting swelling and moderate pain at the left elbow: "I was doing a lot of heavy construction today, I struck my left elbow several times and I now have pain and swelling of my elbow." There was pain and swelling at the olecranon bursa. There was no abrasion or bruising. Diagnosis was left olecranon bursitis. An x-ray was offered but Petitioner wanted to follow up with his own ortho for this, so he was referred there for further treatment, with Dr. Hyre indicating "urgent ortho

consultation." A left elbow sleeve was provided, and Petitioner again refused work restrictions. (Px10). Petitioner testified that he was sent to Edward Hospital for an x-ray and he requested a full duty release to return to work.

Petitioner went to the Edward Hospital emergency room at 6:47 p.m. on 2/28/17 reporting a left elbow injury: "He was throwing large concrete blocks into the back of a pickup truck for work today when he struck his elbow on the edge of the truck. He noted some increased swelling to the electron area today. Minimal pain." A separate note indicated he hit the elbow on the truck around noon. At this facility. X-rays showed olecranon bursa swelling, slight triceps enthesopathy and no acute fracture or other acute abnormality. Diagnosis was posttraumatic olecranon bursitis. Petitioner was offered an Ace wrap but preferred to use his own splint. He was advised to follow up with his primary provider. (Px11).

Petitioner testified he continued to work regular duty through 3/14/17. On that date (the subject of case number 17 WC 08105), it was snowing and he was assigned to a plow truck driving between Cermak Road and I-90 on I-294. He came back to the garage to load salt and fuel the truck, parking outside of the garage to use the restroom. Petitioner testified it was wet and snowy outside, including in the parking lot, at the salt dome or at the gas pumps. Trucks pulling in and out made the garage area wet as well. He testified he was wearing work boots that day (see Px26) and that they were very wet when he came into the office building through the garage door. He testified he also had a snow suit on that was wet at the bottom of the pants as well. He testified he walked between 50 and 150 feet to the garage area. He testified that as he went to go upstairs to the second-floor locker room bathroom he slipped and fell.

A photo (Px2) depicts a view going from the garage into office area. The floor inside the office area is marble. There is an area depicted, the "Time clock area", where there is a bulletin board. Petitioner was planning to go up the depicted stairs to the locker room. Petitioner testified this photo was taken after the alleged accident date but testified that the lighting and dimensions shown in the photo are the same as they were on the accident date. In the room when he entered from the garage were co-workers Nick Berardi and Lorenzo Slack, who were talking near the time clock. Mr. Slack was a relatively new employee at that time, maybe 2 to 3 months. Petitioner walked by them to go up the stairs. He testified he asked if they were clocking out, but he was not sure if they heard him as they didn't acknowledge him. As he went to step on the first stair, he testified he caught it with the toe of his boot, and as he went to go to the second step, the toe of his other boot slipped off the first step and he fell forward onto the stairs, landing on his left elbow and left side. After cursing, he got up and went upstairs. He went to supervisor Don Ryan's office on the second floor and reported he had fallen on the stairs and had severe elbow pain. Petitioner testified that Ryan slammed the door in his face. Confused, he waited for a bit to see if he was coming out or not. After a few minutes Ryan came out, walked past him without saying anything, and took a camera and started taking pictures of the stairs. Petitioner followed him down the stairs. They didn't speak further. Petitioner noted he started taking pictures himself when he didn't think Ryan was taking pictures in the right spot. When they then went back upstairs, Petitioner indicated he had slipped up the stairs, as his boots were wet and there was some water on the stairs. He testified he indicated his boot prints were there. He testified that Ryan then advised him to call Corvel.

Petitioner identified Px3 as a photo he took at approximately 11:57 a.m., which was about five minutes after he first reported the incident to Ryan. He testified that the marks on the floor in the photo are from his boot prints, which showed the path he walked. Petitioner testified he stepped up on the stairs with his left foot, toe on the edge of the step, went to push off to put his right foot on the next step and his left toe slipped off. He testified that he may have asked Berardi and Slack if they saw what happened, but he didn't stop to talk to them. He didn't think they were still present there when he went to take the photos, and he indicated he hadn't told them anything about the injury or what happened.

Philip Cassman testified that he works as a maintenance section supervisor for Respondent, and that he was the Petitioner's immediate supervisor working out of Maintenance facility 2 in Hillside in 2017. Don Ryan was the manager of the maintenance facility. Cassman testified his duties include giving out daily job assignments, following up on them and dealing with safety issues. Mr. Cassman was aware of Petitioner's three pending workers' compensation claims. On 2/27/17, Petitioner came into the office and reported he hurt his back working on the sweeper. He had assigned Petitioner to a road shoulder sweeping job in the number 259 sweeper, and the Petitioner reported hurting his back when he hit a pothole. He gave the Petitioner injury reporting paperwork and advised him to call Corvel. Petitioner had already spoken to Corvel because they had canceled a previously scheduled doctor's appointment that he was supposed to have later that day related to a prior back claim. He then advised Don Ryan that Petitioner reported hurting his back. He then went down to inspect the sweeper, including the seat and tires, and it was operating properly. He testified the machine had an Air Ride seat, which provides a smoother ride. Cassman testified he went with mechanic Jim Murphy to look at the sweeper to make sure the air ride seat was working and that it didn't leak air, and there were no air leaks found. He also testified that in the two years between March 2015 and March 2017, no one had ever complained about problems with the seat in #259. The machine is serviced every 100 hours of use by going through a checklist. He further testified that if the machine breaks down it would be brought in to be fixed, and while he acknowledged that #259 was in the shop quite a bit for mechanical problems, this involved mostly conveyor or broom issues. He doesn't review the repair sheets himself; he is informed of what the problems are by the mechanic. He had no knowledge of physical maintenance records and he could not say how old the machine was in 2017. Mr. Cassman testified didn't spend a lot of time on the machine but has driven #259 himself when he initially was promoted to supervisor in 2015 and it was working fine and did not involve a bumpy ride in his experience. As to the 3/14/17 incident, his understanding is Petitioner was hurt entering the stairway in the building. He verified that Mr. Slack and Mr. Berardi were also EOLs for Respondent, and that there is a time clock in the office building stairwell where employees have to use a badge and fingerprint to punch in and out. On cross-examination, Mr. Cassman testified he had not driven sweeper #259 again after March 2015, at which time it was working fine.

Donald Ryan, Respondent's Section Manager for the Tollway since 2011, testified that he oversees and manages an assigned maintenance facility, currently at the Arlington Heights facility but in 2017 was at the Hillside location, Number 2, and Petitioner was one of his employees there. He gives out the daily assignments to the day shift workers, does other paperwork and goes out on the road to check up on work crews and to look for roadway deficiencies. Mr. Ryan testified that as section supervisor, Mr. Cassman was basically his assistant but that they are more or less equals with the same responsibilities and coordinate with each other on what they are going to do. Mr. Ryan verified his office is on the second floor of a two-level building where the first floor is a hall to the upstairs and the garage where mechanics and trucks are. His office can be accessed from the west side, between a wall and the building, and on the north side by walking through the garage, into the hallway near the time clock and up the stairs.

On 3/14/17, Mr. Ryan acknowledged that there had been a two day show and ice event and the workers were out plowing snow. Sometime around noon the Petitioner came in and advised that he had slipped and tripped up the stairs and hurt his elbow. Someone was present at a table in the common area outside of his office, but Ryan could not recall who it was. He told the Petitioner he thought he had previously hurt the elbow and that Petitioner said he reaggravated it. Mr. Ryan advised Petitioner to contact Corvel. He then got paperwork for Petitioner to complete and testified the Petitioner went to the conference table in the common area while Ryan went to the stairs to take photos of them near the office door, at the landing, and at the bottom of the stairs, which he identified as Rx7. He then went back into his office, closed his door and made the necessary phone calls he needed to make. He testified he took the photos with his cell phone, not a camera, noting the facility got rid of cameras once cell phones were readily available for any needed photos. He estimated he took the photos about 5 to 10 minutes after Petitioner reported the incident. Mr. Ryan could not recall any specifics of where the

Petitioner fell on the stairs and didn't recall the Petitioner ever saying where exactly where he fell, all he recalled is that he tripped up the stairs.

Mr. Ryan testified that he summarized what occurred and agreed there are references to water. He acknowledged that there was snow and ice outside that day and there was some water from the door of the garage in the area of the timeclock, but he did not see any water in the area at the bottom of the staircase. He testified that he didn't see the Petitioner near the stairs when he was talking the photos and didn't see the Petitioner take any of his own photos. Mr. Ryan testified that the floor is terrazzo at the base of the stairs and the stairs themselves are concrete, which are less slippery than the terrazzo floor. He testified that he had not seen Petitioner's photo of the stairs prior to the hearing date, and indicated he did not see the alleged boot marks on the floor at the bottom of the stairs when he was taking photos, just the wear on the floor, and he verified the photos he took accurately depicted the condition of the stairs that day.

Mr. Ryan agreed that Petitioner would have been plowing snow that day and there would have been a number of reasons he might have needed to be outside of the truck that day. Most employees park between the salt dome and building on the north side when they come inside, which he indicated this would be anywhere from 20' to 30' away from the building, while it could be 5' to 10' if you park next to the building. Mr. Ryan testified the Petitioner did not say anything about injuring his back that day and did not initially indicate there were witnesses. After Petitioner went to the company clinic he returned to the office and he and Ryan briefly spoke again, including about Mr. Berardi and Mr. Slack being witnesses, and Petitioner then provided his written statement, listing Berardi and Slack as witnesses. Mr. Ryan did not recall seeing either of them downstairs when he was taking the photos. The next day he testified he approached Berardi and Slack individually to ask what they were aware of, as they were busy on 3/14/17 plowing snow. The Petitioner provided his written statement, listing Berardi and Slack as witnesses. Mr. Ryan testified he regularly deals with workers' compensation claims, and when an injured employee indicates there were witnesses to an incident, he is required to obtain statements from them. He met with Mr. Berardi and Mr. Slack separately in his office between 7:00 and 7:30 a.m., advised them they had been listed as witnesses and that they needed to prepare statements about what they knew. Both of them indicated it was the first time they had heard about Petitioner claiming injury, and each of them completed their own statements (see Rx1 & Rx2). Once he gathers all pertinent information about a workers' compensation claim, Mr. Ryan provides that information to management.

On cross examination, Mr. Ryan testified that Petitioner reported slipping and tripping up the stairs and injuring his elbow, he did not report a back injury. He denied slamming the door in the Petitioner's face and denied being angry. He testified that after he gave the Petitioner the employee injury report packet to complete, Petitioner sat at the conference table in the common area and was completing the documents. He again testified that the Petitioner did not follow him down the stairs when he went to take photos. Mr. Ryan testified that the Petitioner completed an Employee Accident/Incident Report that day, 3/14/17. He testified that he completed the document in Px6 based on what the Petitioner told him. While Petitioner was supposed to complete it and sign it, Mr. Ryan testified he refused.

Mr. Ryan did acknowledge that he checked the box in the documentation indicating injury to the lower back on 3/15/17 but testified that he didn't recall what the Petitioner told him that day. The report states he slipped on some water at the stairs and said he hit his arm while falling or tripping on the stairs. He testified that Petitioner initially said he tripped on the stairs, said there was water in front of the stairs and that he slipped walking up the stairs going to the locker room. Mr. Ryan was not sure if or when he and the Petitioner had a second conversation on 3/15/17. He did witness Petitioner signing the document the next day. As to an indication of striking an object, Mr. Ryan testified that he meant the stairs when he wrote this. Because Petitioner said he slipped on stairs, he took photos of the stairs. Mr. Ryan did not recall what boots or shoes the Petitioner was

wearing. There is water on the floor in that area sometimes, and he testified that building maintenance or janitorial would clean the area, change carpets, etc.

When he was shown the photographs in Px4 & Px5, Nr. Ryan testified that the runner depicted was placed to collect water and dust. The orange cone exists to let people know its slick, noting that the terrazzo is slick when it gets wet. He testified that he would have expected Petitioner's boots to have been wet on 3/14/17. He took the photos in Rx7 between noon and 12:15 p.m. He did say there was water from boot prints in the hallway. While he didn't see the Petitioner do so, he agreed he may have gone down and took photos himself. He agreed the photo in Px3, with an 11:57 a.m. time stamp, depicts marks before the stairs

Mr. Ryan indicated on redirect exam that he may have obtained more information from the Petitioner the day after the alleged accident. He reiterated that the written statement from 3/14/17, Rx6, was completed by Petitioner in his own handwriting, and it indicates he slipped on water and hit his elbow on the stairs with no mention of the low back.

The Arbitrator notes that the photos in Px2, Px4 and Px5 depict the Respondent's office building's lower level. The area is essentially a long room, with swinging glass doors in the front and the gray steel door testified to by the witnesses at the other end. There is a large bulletin board on the wall in the hallway between them, and the board faces the stairwell. As testified to, the floor does appear to be terrazzo and the stairs do appear to be concrete and metal with a solid metal railing. Px3 is a photograph Petitioner identified as one he took on 3/14/17 of the area at the bottom of the stairs. The Arbitrator notes that there are patches of dirty areas at the bottom of the stairs that appear to have been made with shoe wear. The photo is from a cell phone, was taken by someone from a position on the stairs themselves. (Px2 through 5)

Px26 contains side and bottom photos of the Petitioner's boots from the alleged accident date. These photos were purported to show a unique tread on the Petitioner's boots that could somehow be seen in the photos the Petitioner took. However, the only photo that allegedly depicts the marks on 3/14/17 that is in evidence is Px3, and there is no way the Arbitrator can tell whether the marks on the floor were made by any specific boot tread. Petitioner testified that the photograph in Px3 depicts his footprints walking in a semicircle around the railing, and the Arbitrator notes that the location of the marks could be from someone walking from the hallway around the railing and to the stairs.

The Arbitrator does take note that the photos in Px4 and 5, which Petitioner testified were taken by him sometime between September 2017 and May 2018, shows that a carpet runner had been placed in the hallway between the front and gray garage doors, as well as in front of the stairs along with an orange cone. Petitioner testified the cones and the carpet were not present on the alleged accident date and were put in after his injury. The Arbitrator notes that remediation measures that may be taken by a Respondent does not confer liability on them under the Act. However, the Arbitrator does take note of the photos for whatever evidence they may provide with regard to evidence of notice to Respondent.

The Arbitrator also notes that the photo in Px2 appears to have been taken on a day different from both the alleged accident date and the time the photos in Px4 and Px5 were taken, as no carpets were present in the lower level. This photo does depict an "LS" mark that indicates where Mr. Berardi and Mr. Slack were standing at the time of the alleged accident, in front of the bulletin board. The Arbitrator would note that where they were standing appears to be within 5 feet, to 10 feet at the most, from the stairwell, and there would be nothing obstructing their view of the stairs had they been looking at the stairs.

The photographs taken by Don Ryan were also admitted into evidence (Rx7). This includes pictures of the floor and bottom stair, the landing of the stairs, and the floor at the top of the stairs just outside the offices. The

Arbitrator notes that the floor at the bottom of the stairs was quite dirty and appears to be dry, but also acknowledges that this is very difficult to perceive by simply looking at the photos. (Rx7). The Arbitrator would also note that the area photographed by Mr. Ryan is directly at the bottom of the steps and includes the bottom stair, while the Petitioner's photo shows mainly the area just beyond the bottom of the steps towards the glass doors.

The witness statements of Nick Berardi and Lorenz Slack were submitted into evidence. Both statements are dated 3/15/17. Mr. Berardi indicated he did not directly witness Petitioner's accident, and that he was first made aware of the incident "Just now at 7:30 on 3/15/17." (Rx1). Mr. Slack also indicated he did not directly witness an accident, and "Was first made aware when called into the office to ask if I saw it at 7:30 a.m. 3/15/17. (Rx2).

Lorenz Slack testified he began working for Respondent on 1/3/16 as an Equipment Operating Laborer (EOL), with similar duties as Petitioner, but he was still a hands-on trainee. He recalled he was standing in front of the bulletin board near the time clock (see "LS" on Px2) talking to Berardi sometime between 2:40 and 2:45 p.m., as he punched out at 3 p.m. on the dot. They had worked together that day and were talking about something they were looking at on the bulletin board. His back was to the stairs when he peripherally saw the Petitioner walk in through the gray door from the garage. He did not if Petitioner said anything or not. While he was still facing the board, he heard a yell and a kind of foot slap sound. He turned around and saw the Petitioner sitting on the stairs with his elbow on the rail pulling himself up. He testified he was on the first or second stair. He testified he did not see any actual incident and did not see the Petitioner fall. When he heard the sound, he turned around and thought the Petitioner had been joking around. He testified the Petitioner asked, "Did you see that" Berardi asked him if he was alright, Petitioner didn't respond and he went up the stairs.

The next day, Mr. Slack testified that Ryan and Sweeney pulled him into the office to ask about Petitioner. He testified he initially didn't know what they were talking about, and they told him Petitioner hurt himself and said Slack saw him fall down the stairs. He told them he didn't know what Petitioner was talking about and didn't know he was hurt, as he thought the Petitioner had been joking around and he had no idea anything was going on. Ryan asked him to then just then write that he didn't see anything, which he did (Rx2). Mr. Slack testified that he and the Petitioner are both musicians and have worked together a couple times. They weren't close friends, but they would talk outside of work about music a lot.

Cross-examined by Respondent, Mr. Slack verified that the incident had to have occurred sometime between 2:45 and 3 p.m., as that's the only time he would have been in that area. He testified he was in that area for about 15 minutes after washing trucks outside and changing blades on the plow. He denied that this could have been around noon as he never punches out that early. He did not recall seeing anyone's footprints. At that time, he testified a shift would all be punching out, which he estimated would be 12 to 15 guys. They would go to the locker room upstairs to change then come back and sit down until 3 p.m. He acknowledged receiving a text from Petitioner 2 or 3 weeks before his testimony indicating his attorney would be contacting him, and that he hasn't had any discussion with anyone else since that time. He only discussed what had transpired at work with Petitioner's attorney the day of the hearing.

Slack testified that guys in the garage joke around with each other a lot and he reiterated that when Petitioner didn't respond to Berardi asking if he was okay, he assumed Petitioner was joking around. He believed the Petitioner was using his left arm to pull himself up. He estimated he was approximately two to four feet away from Petitioner when he heard a thud and a yell, and he turned around a second later. He was told the next morning by Ryan and Sweeney that Petitioner said he fell on the stairs, and he told Ryan he didn't initially know what he was talking about because he thought Petitioner was joking, but that he heard Petitioner yell, saw him on the stairs, asked if he was okay and Petitioner walked up the stairs.

Nick Berardi, also an ELO for Respondent, testified that he had been off work since 4/23/18 himself due to his own work injury. He has worked together with Petitioner often and testified they shared the same basic job duties. They would work in teams and would all contribute to jobs, and he indicated the Petitioner performed well on the job. He described the areas upstairs and downstairs in the office building as depicted in Px2. Berardi testified he did not recall what the Petitioner's assigned job was on 3/14/17. He saw him at the morning meeting but did not work with him that day. He verified that it was cold and wet that day and that his boots and pants got wet. Sometime between approximately noon and 12:15 p.m. that day he testified he was talking to Mr. Slack, who he worked with that day, and they were looking at something on and facing the bulletin board. He noticed the Petitioner walk in from the garage, they said hello to each other, and he went back to talking to Slack. He testified he then heard a thud, turned and saw that Petitioner appeared to be in the motion of getting up on the stairs. He asked the Petitioner if he was okay, but the Petitioner didn't answer him or say anything more and continued up the stairs. He testified that the thud sounded like someone fell and hit the pavement, causing him to turn around. He saw the Petitioner getting up from laying on the stairs, recover his stability and then walk up. He testified that the floor is slick when work boots are wet.

Berardi testified he was first made aware that Petitioner had an accident and said he got hurt following the morning meeting on 3/15/17. Foreman Don Ryan asked he and Slack to come into the office to prepare a report, indicating he said they were witnesses to him falling on the stairs. Berardi asked if they meant from the day before and they said yes. He agreed he completed Rx1 in his handwriting on 3/15. He reiterated he heard the thud and saw Petitioner getting up from the stairs but didn't know he had been injured at that time. Mr. Berardi verified that the rugs depicted in Px5 were in the building in March of 2018, and he acknowledged that the floor and stairs can be slippery in the building, noting hard toe shoes are required for the job.

On cross, Berardi testified he was working with agreed that while he normally punches out at 3 p.m., he was in the office building at noon because they must have been taking a break. He acknowledged that he and Petitioner became work friends and they would joke around a lot. The bulletin board was about four feet away from where Petitioner was on the stairs and he turned around immediately when he heard the thud. Petitioner was in a prone position when he turned around, lying on his stomach up the stairs. He verified that he prepared Rx1 after being told Petitioner reported falling on the stairs and that he witnessed it. He indicated he didn't witness an injury because he didn't visibly see him fall since his back was turned. He indicated he was made aware of the accident/incident "just now" because he didn't realize Petitioner had been injured. When he had asked Petitioner if he was okay, he didn't say anything, and after collecting himself for a second or two he continued up the stairs. He did not notice Petitioner holding his elbow, but he was looking to see if he hit his head and didn't focus on anything else.

Petitioner testified he was again sent to Advocate by Corvel, and he again saw Dr. Hyre. An initial injury report at Advocate Occupational on 3/14/17 (12:40 p.m.) notes: "Slipped and fell on stairs hitting elbow hard." The progress note states: "According to the pt, while at work, he was in a stairwell talking to coworkers when he slipped on water, fell, and landed on his left elbow. He reports pain and swelling in the left elbow. He does have a previous injury to that left elbow about a few weeks ago and the swelling has been there since that injury. The swelling never subsided from that injury and now he reinjured the left elbow when he fell today." Left elbow x-ray showed an ossific density at the dorsal aspect of the olecranon process with associated soft tissue swelling, concerning for an avulsion fracture. Correlation with point tenderness was recommended. Diagnosis was left elbow contusion, and an avulsion fracture of the olecranon process. Petitioner was restricted from left arm use and referred for orthopedic evaluation. (Px10; Rx4).

Petitioner testified he reported both elbow and back pain at Advocate. Petitioner acknowledged that he only reported elbow pain to supervisor Ryan on 3/14/17 because he had a lot of elbow pain. He testified that by the time he left the clinic the supervisors had gone for the day so he couldn't complete injury paperwork. Petitioner

testified that after being diagnosed with an avulsion fracture the doctor was going to schedule him with an orthopedic surgeon.

On 3/15/17, Petitioner went to the garage at 6:30 am and dictated an accident report to Supervisor Ryan, indicating that he hurt his elbow and low back. Respondent submitted a one-page document into evidence, dated 3/14/17, alleged to have been signed by Petitioner, which states only the following: "Slipped on water at bottom of stairs. Fell & struck left elbow on stairs." (Rx6). Petitioner testified he also completed an Employee Accident/Incident Report Form (Px6) on 3/15/17 where he also indicated back symptoms.

Petitioner testified the 3/15/17 (Px6) was filled out by Don Ryan and that Petitioner then signed it. The Arbitrator notes this document indicates the Petitioner reported an incident occurring at the garage on 3/14/17 at 11:45 a.m. and that it was reported around noon. The document further indicated that he injured the left elbow and low back due to a fall and striking against an object. These are noted via check marks to injury types that are already noted. The incident is described as "coming upstairs to go to locker room", and that he slipped on some water "at or in front of stairs." Berardi and Slack were indicated as witnesses. It also notes the injury was immediately reported to the supervisor. It is signed by Petitioner on 3/15/17 and Mr. Ryan signed off indicating he witnessed the signature. (Px6).

Petitioner testified that when an orthopedic visit had not yet been scheduled for him, on 3/16/17 he contacted an attorney. On 3/16/17, Petitioner saw Dr. Tu at G&T Orthopedics for left elbow swelling following a work injury. Petitioner was noted to be left-handed. He reported that on 2/28/17 he was doing concrete work when the back of his elbow hit a concrete truck. When he later took off his sweater, he noticed the elbow was swollen. He noted he went to Edward Hospital for x-rays when occupational health did not have an x-ray available. Petitioner reported he then returned to regular duty until 3/14/17, when he tripped on some stairs and struck his left elbow. It was noted he was "diagnosed with an avulsion fracture, also started complaining of back pain. Since his recent injury, he has some swelling in the back of his elbow, does not have really any significant pain. He does have lower back pain." Dr. Tu diagnosed traumatic left olecranon bursitis and lower back pain. Dr. Tu opined that the direct trauma to the posterior elbow was a significant contributing factor to the development of the condition. The bursa was aspirated, and the elbow was compression-wrapped. He was released to full duties and advised to use an elbow pad. He was referred to neurosurgeon Dr. Salehi for the low back. (Px12). After draining his elbow, Petitioner testified that Dr. Tu recommended an elbow pad and felt he didn't need surgery. Petitioner testified on 10/11/19 that his elbow was fine and he was having no problems with it.

Petitioner initially saw Dr. Salehi on 3/23/17. Petitioner reported on 3/14/17 he fell down some stairs at work and since that time had left elbow and low back pain. He denied pain or numbness radiating to the legs. He was working full duty. Petitioner acknowledged that he was hit by a car at work many years prior, had low back pain, three months of therapy and was "then told to return to work. He stated that since that time he had some low-grade back pain but that it was never to the degree that it is currently." Physical therapy and lumbar MRI were prescribed. (Px9B; Px13A).

On 4/13/17, Petitioner returned to Dr. Tu. He reported his elbow symptoms had improved with aspiration but that about a week after his original work injury he started to get left wrist pain: "He feels that it was after a fall at work since his injury, he has difficulty with extension of the wrist." Dr. Tu diagnosed a possible triangular fibrocartilage complex (TFCC) tear and ordered a left wrist MRI. He was allowed to continue regular duty. (Px12).

Lumbar MRI films obtained on 4/19/17 indicated mild loss of intervertebral disc space height and loss of normal T2 hyperintensity of the disc material with a small posterior broad-based disc protrusion. There was minimal associated central stenosis and foraminal narrowing. (Px9B; Px13A; Px14).

On 5/2/17, Petitioner reported 2-3/10 low back pain at rest that could go up to 7/10 with work activities. He denied radiation of pain. Dr. Salehi noted single level degeneration at L4/5 with a small paracentral and right disc bulge. He indicated Petitioner had low back pain secondary to aggravation of L4/5 disc disease/annular tear and recommended physical therapy, noting Petitioner could be a fusion candidate in the future if his symptoms persisted. Mobic was also prescribed. (Px9B; Px13A).

On 5/4/17, Dr. Tu indicated Petitioner reported continued difficulty with full wrist extension and that they were still awaiting MRI authorization. (Px12).

When Petitioner followed up on 5/30/17, he reported no low back improvement with therapy, which is consistent with his testimony. Dr. Salehi continued to advise therapy and allowed Petitioner to continue to work full duty. On 6/20/17, Petitioner reported his low back pain was mild, but he lifted something heavy at work on 6/11/17, aggravated the pain to where it was hard to move and took a couple sick days until he returned to a baseline level. He continued to deny radiation. Noting the pain could be due to L4/5 or possibly also the SI joints, Dr. Salehi prescribed diagnostic and therapeutic SI joint injections along with ongoing therapy and continued him on regular duty. (Px9B; Px13A).

On 7/13/17, Petitioner saw Dr. Farag at Midwest Anesthesia and Pain Specialists based on the SI joint injection recommendation. Petitioner reported his elbow problem had mostly resolved but was still sore from time to time. The back pain was mostly left-sided, occasionally right-sided, with occasional pain down the leg to the knee if the back was palpated firmly by the physical therapist. Petitioner reported the pain made work difficult and that he wasn't playing as much golf as he used to, his favorite pastime. He had been working unrestricted in what Petitioner described as a heavy job and "he prefers to continue working without restrictions." Dr. Farag recommended the SI injections, a back brace, physical therapy, NSAID cream and lidocaine patches. (Px16).

On 7/25/17, Dr. Salehi noted continued left low back complaints with increased intensity based on work activities. He indicated "when the pain is significant it will radiate down the left leg otherwise he denies any radiating leg pain or paresthesias." It would occasionally radiate to the right low back. He was to undergo SI joint injections on 8/3/17 and continue regular duty. On 8/21/17, Petitioner denied pain radiating into the legs. At this point Dr. Salehi stated that the Petitioner was not working because his restrictions were not being accommodated, and that he "continued" to recommend L4/5 fusion surgery. He was advised to stop smoking and to continue on light duty status. (Px9B; Px13A). The Arbitrator notes that no records were submitted prior to this visit which reflect light duty restrictions or a specific surgical recommendation.

On 8/3/17, Dr. Farag repeated his 7/13/17 recommendations. (Px16). On 8/18/17, Petitioner saw family physician Dr. Wojcik, who noted he injured his back when he fell down stairs at work in March and was there for a note indicating he was limited to certain work duties because he had been using vacation and sick time and he had no more vacation time left to use until 9/21/17. He noted he was waiting for Respondent to authorize the SI injection. Tramadol helped but he couldn't take it at work because it made him feel high. (Px9A).

Petitioner testified that Dr. Wojcik restricted his driving and operation of heavy machinery, not physical activities, and that Respondent could not accommodate this. Petitioner testified that when Dr. Wojcik gave him work restrictions from 8/19: "I asked for September 20th because that's my anniversary date, and I would get three more weeks (of) vacation. So I was hoping that if the injections still weren't approved by then, I can at least get back on the clock and ease through my vacation time to get the restrictions, but then I got the injection, part of that. The injection didn't work." He testified he gave an 8/18/17 note reflecting this restriction to Don Ryan on 8/18/17 or 8/19/17, and that Ryan told him he would have to call his boss about it. On 8/19 or 8/20/17, he received a call indicating the Respondent could not accommodate the restrictions and he was then off work.

Petitioner testified he had different counsel when Dr. Farag had prescribed the injection and back brace, which was never approved. The injections weren't performed until August and September. Petitioner denied being told why Respondent would not authorize these prescriptions. He had continued to work regular duty from March through 8/14/17.

On 8/29/17, Dr. Farag performed left SI joint injection. (Px16). It appears that Petitioner attended therapy at ATI from 5/10/17 through 9/13/17, at which point the therapist indicated Petitioner had reached maximum medical improvement (MMI) with regard to therapy as he had plateaued without meeting almost any of the planned short or long term goals. (Px9B; Px13A; Px15).

On 9/19/17, Petitioner told Dr. Salehi the SI joint injection did not help. The report states: "He was given Tramadol for pain about a month ago and since then has been off work as he is not able to drive." Left low back pain with occasional tingling in the left buttock was reported. Given no relief with the injection, Dr. Salehi opined the pain was most likely related to the L4/5 condition. He was changed from Tramadol to Celebrex and given light duty restrictions (no lifting over 20 pounds, no push/pulling over 35 pounds, no bending or twisting), including no driving of a company vehicle. It was noted he would follow up in 4 weeks and be released to full duty. (Px9B; Px13A).

Petitioner testified that Dr. Farag had provided him with Tramadol at his office, and while it helped his back pain, it made him feel kind of "loopy", which he couldn't have while operating commercial machines at work, so he had to take days off while he was waiting for the injection to be approved to avoid driving under the influence. He testified he was told he could no longer take vacation days off for this alleged injury after 8/14/17. Therefore, if he worked regular duty and hurt someone he would have to take a drug test, and he testified he didn't want Respondent to take on that liability. On cross exam, he testified that he continued to drive his car and could not recall if the medication impacted his personal driving. He noted that a CDL license has a higher standard than a regular driver's license.

Petitioner testified that Dr. Salehi indicated his bills weren't being paid by Respondent, and that his prior attorney hadn't informed him that his claim was being denied. He would call his boss every or every other week to report that he still had restrictions. Petitioner testified his understanding of Respondent's policy is that he would need a full release before he could return to work, and this was what Don Ryan told him in August after getting his work restrictions. At some point a Mr. Sweeney became the new section supervisor below Ryan and that is who the Petitioner would talk to weekly or biweekly in August and September to indicate he still had restrictions. Petitioner testified therapy at ATI wasn't helping after 4 months, and neither did the injection, so more aggressive treatments were planned. He had expected he would receive TTD when he went off work on 8/15/17 since Respondent was paying for therapy.

On 9/26/17, Petitioner returned to Dr. Farag and indicated he didn't think the injection helped very much after having 75% improvement the day of the injection. He was taking Tramadol but hadn't tried lidocaine patches. (Px16).

On 10/17/17, Dr. Salehi reviewed a 9/6/12 MRI ("disc disease at L4/5 with mild height loss and small central herniated disc") and compared it to the 4/19/17 films, indicating they showed further loss of T2 signal of the L4/5 disc. Light duty was continued and he was to return following a court date to determine if he would proceed with treatment of obtain a functional capacity evaluation (FCE). On 11/14/17, Dr. Salehi stated that Petitioner "may be a candidate for a lumbar fusion should his pain become unbearable." Light duty restrictions were continued. (Px9B; Px13A). Petitioner testified when fusion was discussed at this point, he was basically sedentary.

On 1/2/18, Petitioner reported continued left low back pain that was worsening with radiation into the legs about once a week. He was not working as light duty was not being accommodated. Dr. Salehi indicated the pain was due to L4/5 disc disease/annular tear, and given the pain was becoming intolerable he recommended an L4/5 decompression and fusion surgery. Petitioner reported he had quit smoking and would need to continue that for at least 9 months post-surgery. Restrictions were continued. Surgery and light duty were again continued on 2/6/18 while awaiting authorization. Restrictions were again continued on 8/21/18. (Px9B; Px13A).

Dr. Salehi testified via deposition on 6/26/18. He first saw the Petitioner on 3/23/17 on referral from Dr. Tu for the low back, as Dr. Tu is not a spine surgeon. The Petitioner reported his alleged 3/14/17 work accident and "a chronic history of lower back pain, but he called it low-grade pain prior to this injury", which Petitioner indicated went back to when he was struck by a car at work. Petitioner indicated on 3/14/17 that he "fell at work down the stairs, injuring his elbow and low back." Dr. Salehi testified he determined that Petitioner was a lumbar fusion candidate. He testified that 80% to 90% of patients with low back pain due to degenerative disease get better with conservative care and time, but they become fusion candidates if they don't get better and remain in moderate to significant pain. He testified that Petitioner's 2017 lumbar MRI showed an L4/5 annular tear causing mechanical back pain and conditions of disc disease and then the disc bulge as a result of the tear. He agreed that it was a disc bulge and that disc material had not necessarily herniated. The tear caused axial back pain, not radicular pain, and the axial pain is due to the tear impacting sensory nerves on the disc surface. (Px8; Px9).

Dr. Salehi testified he generally will bring up possible surgery after 6 months of conservative care (therapy, injection(s), and time) without a satisfactory resolution. If the patient at that point declines surgery, there would be an MMI determination and recommendation for functional capacity evaluation (FCE). Petitioner's complaints were ongoing back pain at rest from two to three, going up to seven out of ten with activity, and Dr. Salehi's impression was Petitioner's improvement with conservative care was not significant. In January 2018, he complained that his condition was worsening, so Dr. Salehi recommended surgery. He did testify that Petitioner's complaints of pain radiation to the legs or the leg giving way was referred pain from the back and not radicular. (Px8; Px9).

Dr. Salehi opined that the incident of 3/14/17 was an aggravating event that worsened the Petitioner's preexisting low grade low back pain. He testified that he reviewed the Petitioner's 2012 MRI films as well and that the 2017 films showed a progression and worsening of his L4/5 disc condition. He testified that a fall on the stairs could easily have aggravated the disc, as it was already in a worsened state, and that Petitioner reported an increase in his symptoms versus prior to 3/14/17. He testified that Dr. Bicek's report of Petitioner complaining of low back pain ranging from 2/10 to 5/10 in February 2017 does not impact his opinions. Asked if the changes shown on MRI was a natural progression or one that could have been caused by trauma, the doctor testified: "Either/or. I mean, I guess it would be impossible to say one way of the other, but both would be a competent cause of that progression." As to Petitioner's complaints of increased pain bending over to pick up a litter box, Dr. Salehi testified that "any forward flexion posture puts more pressure on the disc and loads up the disc, and they would have more symptoms from it." Pending surgery, he testified that Petitioner was unable to do his regular job. (Px8; Px9).

On cross-examination, Dr. Salehi acknowledged he was not told when the Petitioner had been struck by a car and testified that the Petitioner did not inform him that he had previously discussed lumbar surgery with a surgeon. His impression was that only conservative care had been considered at that time. While he agreed this is information he would want to know, he denied that this impacted his causation opinion. He first learned Petitioner had undergone a prior lumbar MRI when he brought a CD of the 9/26/12 films into his office on 10/17/17, which Petitioner acknowledged in his testimony. Dr. Salehi agreed Petitioner's primary pre-accident

diagnosis for his preexisting back pain was degenerative disc disease, and he agreed that this is a condition which slowly progresses over time. He again indicated it is impossible to determine if degeneration seen on MRI is due to this progression or a trauma, so he isn't surprised to see it in the regardless of trauma. (Px8; Px9).

Dr. Salehi testified that Petitioner just told him he had a fall on the stairs and had pain in his elbow and back. He wasn't any more specific than that, including whether he had symptoms immediately or within days afterwards. He did not know how many stairs he fell down, but assumed it was more than one: "It wasn't like he just missed the step. He came down – he came down on the body, and it's like he may have taken the blow with his arm." He testified that back pain from a trauma can take a few days to occur, or Petitioner's elbow injury severity could have masked a back injury. Dr. Salehi corrected his direct testimony, where he agreed he'd held Petitioner off work early on, testifying that he hadn't done so, and that Petitioner continued to work so he could make money. Respondent's counsel pointed out that Petitioner had been working up to the point he saw Dr. Salehi that he wasn't hurting for money at that point, and Salehi testified he was still having symptoms. He initially issued work restrictions on 7/19/17, noting Petitioner had been unable to drive after he started taking Tramadol. Dr. Salehi testified he took Petitioner off the drug at that point, as he "usually don't like patients on narcotics for chronic back pain." He testified he started Petitioner on Celebrex, and as to why he then continued to hold him off driving despite ending the narcotic medication, Dr. Salehi testified that if the company vehicle involves bouncing up and down, that is what he was actually restricting, not general car use. He acknowledged Petitioner indicated he was continuing to take Tramadol on 11/14/17, testifying he wasn't prescribing it and possible Dr. Farag was. He agreed he had not spoken to Dr. Farag about Petitioner nor had reviewed any of Farag's records. He testified that SI joint injections may have been prescribed by Dr. Farag, and when the injection failed it indicated "they were barking at the wrong tree." (Px8; Px9).

Dr. Salehi was not aware Petitioner had multiple February and March 2017 workers' compensation claims until he was informed of it by Petitioner's attorney on the day of his deposition, and he was not aware of any pre-3/14/17 medical records. Dr. Salehi agreed that other events, such as lifting a cat litter box, could "aggravate" Petitioner's back condition, but that when it comes to the accident itself, what he means by "aggravation" is Dr. Salehi explained that his definition for aggravation for a preexisting condition is "something that materially changes the spine so the pain keeps going, you know, at the high level." The more minor events are something that increases pain at that moment but is temporary. He did not see any Waddell signed regarding Petitioner. Dr. Salehi acknowledged that the issue of causation can be complicated when there are multiple reported accidents. (Px8; Px9).

10/15/18 pre-op testing with Dr. Bicek indicated no contraindications to surgery. (Px9B). Petitioner testified he was continuing to take medication and use a lidocaine cream but that they did not really help. He was continuing to have pain up to 6/10 to 7/10 with exertion and a return to 3/10 at rest. He reported no real social life due to pain and lack of funds. Petitioner testified the planned 10/31/19 surgery was being authorized via his group health carrier.

Subsequent to his 10/19/18 testimony, surgery was performed by Dr. Salehi on 10/31/18 involving decompression and fusion at L4/5, and including facetotomy, discectomy and arthrodesis of the endplates. Post-operative diagnosis was an L4/5 annular tear resulting in mechanical back pain and degenerative disc disease. (Px9B; Px17).

Petitioner testified he was continuing to follow up with Dr. Salehi through the time of his 10/11/19 testimony. On 11/13/18, he indicated to Dr. Salehi that he was taking up to 10 to 12 Norco per day with low back pain. Dr. Salehi advised him to limit this to 6 and increased his Robaxin frequency and ordered physical therapy to begin. Petitioner was continued off work, noting at the next visit he was to be released to light duty, which was to last

for 6 months post-operatively. (Px9B; Px13B). Therapy at ATI was reinstituted starting on 11/21/18. (Px13B; Px15)

On 12/27/18, Petitioner reported he was doing very well with little if any pain. He was not taking any medication but "does admit to having smoked a couple of cigarettes recently." He was to continue therapy for 6 more weeks and was released to light duty (no lifting over 20 pounds, no push/pulling over 35 pounds, no bending/twisting more than 3x per hour, and alternate sit/standing every 30-45 minutes as needed). (Px13C).

Interestingly, a Modified Oswestry Survey completed at ATI indicates Petitioner reported his pain was bad and he could only lift very light weights, though he didn't need to take medication. His pain prevented him from sitting more than a half hour or standing more than an hour. (Px15A). ATI indicates the Petitioner was discharged from therapy by Dr. Salehi as of 2/4/19., though it is unclear why as he was showing improvement and had not yet reached all of his planned goals. Therapist Nicole Milnamow's note states: "The patient did not meet the remainder of the long-term goals because: The patient has reached maximum medical benefit from therapy and has been discharged from therapy." (Px13C; Px15).

On 2/6/19, Petitioner reported he was doing very well with no pain at all, just tightness and muscle pain into the bilateral hips. He denied leg pain or paresthesias. He was to continue home exercise and light duty restrictions. On 3/21/19, Petitioner was doing well, noting some sharp low back pain when he wakes up that resolves once he stretches. He denied leg pain or numbness and he remained non-smoking. He was performing home exercise and trying to stay active. Home exercise and light duty restrictions were continued pending healed fusion, after which work conditioning was planned. (Px13C)

Documentation dated 7/29/19 indicates that the Petitioner was applying for Social Security Disability. However, it appears that documentation completed by Dr. Salehi on 8/14/19 indicated very little expected limitations on Petitioner's abilities. (Px13C).

Petitioner acknowledged a prior work injury to his low back when he was struck by a car in August 2012. A 2015 Hearing was held on the issue of a herniated disc versus an annular tear versus a strain. He received TTD, but treatment was in question. Petitioner returned to unrestricted work duties on 11/25/12. He was still in pain, but Dr. Mollsen told him the pain wouldn't go away overnight and said to wait a year and see how he did. He treated at DuPage. He went back after a year, late 2013.

Petitioner testified that he is required to return to work within two years of being off work in order to remain in his position.

On cross-examination, Petitioner testified supervisor Ryan closed the door almost immediately after he reported the slip and fall on the stairs, and that he was taking photos of the stair areas outside the office, at the landing and on the ground floor. Petitioner testified he didn't tell Ryan where on the stairs he fell before Ryan went to take photos. He agreed he only told Ryan he hurt the left elbow on 3/14/17 and didn't complete any paperwork that day 3/14, testifying he is left-handed and wasn't able to use the left arm to write. However, when he was shown Rx6, he agreed the documentation was in his handwriting and signature but did not recall writing anything on 3/14/17. Petitioner says he wasn't provided with this documentation in a FOIA request sent to Respondent. While Don Ryan testified he took photos using a cell phone, Petitioner reiterated that Ryan was using a camera when he took the photos.

As to his back condition, the Petitioner testified that at the doctor's office on 3/14/17 his elbow was in severe pain. He acknowledged he still was having some back pain from the prior incidents but couldn't say if his back pain was worse that day. When his elbow pain subsided, he noticed his back hurting.

Petitioner testified that Slack and Berardi were about 10 to 12' away when he fell, and he assumed they would have seen or heard him fall. He may have said something to them as they did turn and acknowledge him, but he testified he was embarrassed and got up pretty quickly, so they didn't come help him. He may have asked if they saw what happened. He fell forward and his entire body was on the stairs, testifying he came down on his side across 4 or 5 stairs. He may have sat down on the steps before he arose. After he fell and he looked back, there was water on the floor. He listed Berardi and Slack as witnesses because they were present. He testified that one of them may have asked if he was alright. He didn't say anything to them about his left elbow.

Petitioner indicated he didn't have further treatment following the 2/5/17 incident because he was told he had bursitis and was advised to return to work, and the Respondent wasn't approving physical therapy. He did not recall whether he had been informed that it wasn't being approved on 3/14/17 before going into the garage. He was wearing the seatbelt on the street sweeper but testified the seat itself goes up and down along with the seatbelt. He estimated he rose 8 to 12 inches up to hit his head on the roof.

Regarding his 2012 back injury, Petitioner acknowledged that surgery was denied in 2014 or 2015. He testified he changed his diet and started working out at that point and got back in great shape prior to these work incidents. He did tell Salehi he had a prior back injury years before, but otherwise indicated he had typical aches and pains that everyone has from various activities, but nothing that would prevent him from his routine. He testified he wasn't sure if he told Dr. Salehi that Dr. Deutsch had recommended disc replacement surgery. He did tell Dr. Salehi he had severe back pain in 2012, and he probably said he had surgery prescribed at that time. He agreed he didn't return to Dr. Deutsch again after his request for surgery was denied after a hearing.

Petitioner agreed on further cross that he had been mugged and car jacked on 4/19/17, where he was thrown to the ground, got kicked in the head a few times and had his wallet and car stolen. He believed it was the same day he had his MRI. He reiterated that he continued working without restrictions both before and after 3/14/17 until August 2017. He testified he may have told co-workers he was having problems while continuing to work between March and August 2017, but he agreed he never told Don Ryan about back problems between 3/17 and 8/17. Asked for more detail about the alleged accident on cross, Petitioner testified he didn't think his left boot made it onto the step, it was on the edge. The stairs are concrete, not marble like the floor.

Petitioner testified he last communicated with Lorenz Slack in October 2017 when he asked if he had given a witness statement because he had tried to obtain Slack's and Berardi's statements via a FOIA request. He testified that Berardi called him the night before his testimony asking where he had to go. That was the only discussion they had. He testified that he did text Slack a few weeks before the hearing to let him know his attorney was likely going to subpoena him to testify and he never got a response.

Petitioner agreed he used a phone to videotape himself sliding across the floor at his workplace in Spring of 2018, indicating the floor was in the same condition it had been in at the time of the accident, as he told Don Ryan his claim was being denied and he wanted to show the area was slippery even when it was not wet. He did the area by the stairs and the upstairs floor. He no longer has that video because his phone it was on was taken when he was mugged. He did show it to his dad.

As to the handwritten note signed by Petitioner, which stated 3/14/17, he testified he was asked to complete it by his boss to document what occurred. As to his indication of slipping at the bottom of the stairs, he testified he believed he got up facing the bottom of the steps and saw the boot prints at the bottom of the stairs, and this is what he was referencing. On redirect, Petitioner wasn't certain when he wrote the handwritten note dated 3/14/17. He came in to complete the incident forms and medical release on 3/15/17, and Don Ryan actually

wrote it out for him. When he returned to work the following Monday, he may have given his statement. He indicated 3/14/17 as the date of the injury, not an indication of when he wrote it.

He testified he continued to perform the weightlifting and cardio routine he had been doing from early 2016 after he fell on the stairs, as it helped his symptoms, though he said he eased up on the weights after the initial 2017 back injury. His back got worse after the fall on the stairs and he stopped doing exercises that would harm his back.

On rebuttal following Mr. Ryan's testimony, Petitioner again denied that supervisor Ryan gave him paperwork to complete on 3/14/17, reiterating that he closed the door on him and then walked by him when he came back out to take photos, and other than Ryan advising him to contact Corvel when they returned to the office, they had no other conversation. He testified that Ryan ultimately asked him the questions and filled out the accident report for him, around 6:30 a.m. on 3/15/17, because he couldn't do it himself do to his left elbow injury, and that the form (Px6) indicates he reported injuring both his elbow and his low back to Don Ryan while they were completing Px6, not just the elbow. The Petitioner reiterated that his boots were wet when he came in the building on 3/14/17 to refill the truck with salt and fuel, and that there had been other times that day where he had to get out of the truck and got wet.

Petitioner also testified that he was very familiar with the street sweeper machine, as he would drive it approximately twice a month for 10 years, and that the seat in that machine had a slow air leak. There was a button he would have to use to add air every 10 to 15 minutes, but on that day it had been deflating, and the pothole he hit was big enough that it caused him to go up and strike his head on the roof before coming back down onto a seat with no air in it. He testified that the machine had a lot of problems and was out of service a lot.

Cross-examined, the Petitioner testified he prepared the documentation in Rx6 a number of days after 3/14/17 at the request of the Respondent, and he put the 3/14/17 date on it because that was the day he was injured, and he gave this documentation to either Mr. Ryan or Mr. Cassman within a week of the alleged accident. He indicated that after Ryan slammed the door in his face, he didn't ask him why he was taking photos at the wrong locations because he didn't want to agitate him any further. He testified he knows he said some profanities when he fell on the stairs and had a severely injured elbow, but he got up relatively quickly because he was embarrassed about falling. As to the street sweeper, Petitioner testified they go no more than 10 miles per hour while sweeping is occurring, but he was driving at highway speeds on the way back to dump when he hit the pothole. He had no records of maintenance to the sweeper.

Between the time of his October 2018 testimony and his updated testimony on 11/14/19, the Petitioner testified he'd undergone the 10/31/18 lumbar fusion surgery with Dr. Salehi, and believed he had therapy at ATI from the third week of November 2018, with progressing activities, until his 2/4/19 discharge. He testified that on 3/21/19, Dr. Salehi felt healing of the fusion was not yet complete. While Dr. Salehi recommended work conditioning along with a home exercise program when physical therapy ended, Petitioner testified he did not attend work conditioning because no one was paying his bills and he didn't feel he was ready for it at that time. As his bills were not being paid, he told Dr. Salehi he wanted to do his regimen at his own gym, as he already knew all the exercises he had been doing, and that Dr. Salehi told him this was okay. Petitioner testified that he mainly did a lot of stretching and mainly leg presses, resistance band training, rowing machine type motions and wall squats, including with a medicine ball.

Petitioner testified he was released from Dr. Salehi's care on 7/23/19, and that he asked him to release him as of 8/12/19, which he did, and Petitioner returned to his unrestricted job duties on 8/12/19. He testified that since he returned to work, he has been a little more cautious than before and that he now does ask for help if needed,

mainly with heavier lifting. Petitioner testified he did not receive TTD while off work but did receive disability benefits through his retirement benefit program, indicating this could be replenished "one way or another." He has no pending appointments but planned to see Dr. Salehi for a 6-month follow up in February or March 2020. He continues to work out at his gym prior to going to work at 7 a.m., and this includes walking, stretching and light lifting.

The Arbitrator reviewed the surveillance video presented by Respondent covering three dates: 9/26/17, 2/14/18 and 2/17/18. All begin at what appears to be Petitioner's apartment complex parking lot. On 9/26/17, the Petitioner was seen at approximately 10:12 a.m. walking to his car. He gets inside and can be seen twisting to his right twice to reach into the back seat to perform some activity while seated in the driver's seat. It is difficult to see what exactly is happening inside the car. The Petitioner is then seen bending from outside of the car to reach to the floorboards of the driver's, passenger's and rear seats to pick up trash. He then drives to buy cigarettes at approximately 10:16 a.m. The next activity depicted is Petitioner arriving at Dr. Farag's office at approximately 10:50 a.m. After leaving at 11:23 a.m., Petitioner is seen driving to O'Reilly Auto Parts and then to a Menards or Home Depot. However, he is not shown doing anything beyond walking into the auto parts store. He returns to the apartment at 12:14 and no further video is depicted. The total amount of time filmed was 12:34. (Rx5).

Petitioner is seen briefly walking to his car and moving it within the lot at 11:06 a.m. on 2/14/18. He is seen on 2/17/18 very briefly returning to the apartment complex and backing into a spot. Each of these videos were just over 4:30 long and they show no activity of Petitioner. (Rx5).

Petitioner's prior workers' compensation claim against the Respondent regarding the 8/1/12 incident where he indicated he was struck by a car was identified as case number 12 WC 29972, and the Respondent submitted the arbitrator's decision in that matter as Rx3. The Arbitrator notes that the factual findings included in that case indicate the Petitioner sought treatment for his low back and left knee, and had a disc replacement surgery recommended by orthopedic surgeon Dr. Deutsch. Arbitrator Kane in that case noted the dispute was based on the Petitioner undergoing three months of care for the low back, after which he returned to full duty work on or about 10/30/12. Over a year later he was noted to have returned to doctors with low back complaints. Petitioner saw Dr. Deutsch on 8/27/14. Arbitrator Kane noted that Dr. Deutsch was the only physician who described Petitioner's condition as involving a disc herniation. He disagreed with the diagnosis of a lumbar strain at the time of the 8/1/12 incident based on Petitioner's stated history that conservative treatment had not been effective and that "the symptoms never resolved other than for short periods of time." (Rx3).

Arbitrator Kane determined that the history indicated in the Petitioner's treatment records following the accident were inconsistent with what he told Dr. Deutsch, i.e. that conservative treatment had not improved his condition and he had ongoing pain after October 2012. The arbitrator found it not credible, along with the idea that Petitioner had continued to perform his heavy work duties routinely while having ongoing significant pain ("It is described as a heavy duty job and it would not be possible for the petitioner to work in such a position for more than a year with complaints and not see a doctor, especially since he was already seeing a doctor for a knee injury and attending physical therapy for approximately two months in 2013. Most critically, the petitioner freely testified that there was an unspecified time when his symptoms began again."). The arbitrator noted that Petitioner's indication that he began to experience pain in his back again at some point contradicted his claim that his back problems had never resolved after August 2012. (Rx3).

Petitioner testified that he still has unpaid medical expenses which he alleges are related to one of the accidents involved in the consolidated claims. His alleged expenses are contained in Px18 through Px25 and Px27.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The parties stipulated to a 2/27/17 accident. While the initial Application for Adjustment had been filed for 2/28/17, the Petitioner amended this at the hearing to 2/27/17. The Arbitrator notes that the original Application references a low back injury, not an elbow injury (see Arbx2).

The Arbitrator notes that Petitioner testified to both a 2/27/17 accident which involved driving the street sweeper and injuring his back, as well as a 2/28/17 accident where he was loading concrete into a pick up and struck the left elbow on a truck. This latter incident does not have an Application for Adjustment filed. As such, the Arbitrator notes that the Petitioner failed to prove a 2/28/17 accident as there is no claim pending for same.

As to the 2/27/17 incident, the Petitioner testified he was lifted off the street sweeper seat when he hit a pothole while driving the vehicle at highway speeds, striking his head on the vehicle ceiling. This was promptly reported. The Arbitrator finds that the Petitioner's low back condition on 2/27/17 was causally related to the 2/27/17 accident.

That being said, the Arbitrator further finds that any back injury the Petitioner sustained that day was a temporary aggravation of a longstanding preexisting low back condition. The Petitioner originally injured his low back at work in 2012 when he indicated he was struck by a moving car which then came back and ran over his foot. As noted above, that matter went to hearing and the prior arbitrator indicated Petitioner sought treatment for his low back and left knee and ultimately had a disc replacement surgery recommended by surgeon Dr. Deutsch in August 2014. Arbitrator Kane in that case noted the dispute was based on the Petitioner undergoing three months of care for the low back, after which he returned to full duty work on or about 10/30/12, then over a year later returned with ongoing low back complaints.

In this case, while the accident was stipulated, the Arbitrator believes the facts indicate the Petitioner sustained a minor injury to the low back. While he testified that he jumped almost a foot and hit the ceiling, he also testified that he was wearing a seatbelt. It does not seem feasible to the Arbitrator that one would jump that high, especially given the testimony that he didn't lift off of the seat but rather that the seat also raised that high. His testimony that the seat was losing air conflicts with the testimony of Mr. Cassman, who testified that he and a mechanic looked at the machine after Petitioner reported the incident and found no issues with the seat or anything else. It is entirely possible that the Petitioner hit a pothole, jarred his back and felt back pain. However, there was no real turning point indicated in the evidence where the Petitioner's underlying condition or symptoms changed significantly. He reported no neurologic symptoms at Advocate, received a steroidal dosepak and he specifically requested a release to return to regular duty. He noted his prior history of herniated discs. While he testified he was referred to the Illinois Back Institute by Advocate, their note indicated Petitioner was requesting this referral. He testified he was feeling "about 90%" when he returned to work on 2/28/17, and proceeded to work with 10 bags of concrete and moved about "5 tons of broken concrete", working with two other workers to fill the back of a pick-up truck well above the truck sides.

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 claims outstanding medical totaling $27,320.52. (Arbx1). However, this also is claimed in all three of the consolidated matters, so it is unclear what portion of this amount is alleged to be related to the 2/27/17

accident involved in this case. The Arbitrator finds that the Petitioner's initial treatment at Advocate on the accident date is causally related to the 2/27/17 accident and the Respondent's responsibility. The Arbitrator did not locate any medical bills which appear to be related to this accident date in the Petitioner's Exhibits (see Px18 to 25 and Px27), but if the Advocate charges are part of the record and remain unpaid, the Respondent is liable for same pursuant to Sections 8(a) and 8.2 of the Act.

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

No prospective medical treatment was recommended to Petitioner on 2/27/17 other than medication, a Medrol dosepak. Therefore, the Petitioner's request for prospective medical treatment is denied.

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:

Per Arbx1a, Petitioner claims entitlement to TTD from 8/18/17 through 9/27/18. The Petitioner is not claiming any unpaid TTD relative to the 2/27/17 accident, and he testified he continued to work full duty for Respondent through 8/14/18. Petitioner's claim for TTD resulting from the 2/27/17 accident is denied.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that while Penalties and Attorney Fees were indicated as a possible issue in the Request for Hearing form, Petitioner's counsel indicated that this was an undetermined issue and that it would be determined post-hearing whether a Petition for Penalties and Fees would be filed. The Arbitrator has not received such Petition, and as a result the Arbitrator finds that this issue has been waived. The Arbitrator would also note that Sections 19(k) and 19(l) do not otherwise appear to be applicable in this case based on the greater weight of the evidence submitted.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC008105
Case Name	PHILLIPS,LONNIE v. ILLINOIS STATE TOLL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0179
Number of Pages of Decision	29
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Steven Scarlati
Respondent Attorney	Robert Delaney

DATE FILED: 4/21/2021

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

LONNIE PHILLIPS,

Petitioner,

vs. NO: 17 WC 8105

ILLINOIS STATE TOLL
HIGHWAY AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 30, 2020 is hereby affirmed and adopted.

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

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

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: **4/21/2021**
o: 4/15/21
BNF/kcb
045

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Christopher A. Harris*
Christopher A. Harris

/s/*Marc Parker*
Marc Parker

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

21IWCC0179

PHILLIPS, LONNIE
Employee/Petitioner

Case# **17WC008105**

17WC008104
17WC035924

ILLINOIS STATE TOLL HWY AUTHORITY
Employer/Respondent

On 4/30/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0312 BOUDREAU & NISIVACO LLC
ALAN BOUDREAU
120 N LASALLE ST SUITE 1250
CHICAGO, IL 60602

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

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

1024 IL STATE TOLL HIGHWAY AUTHY
2700 OGDEN AVENUE
WORKERS COMPENSATION DEPT
DOWNERS GROVE, IL 60515

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

APR 30 2020

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

21IWCC0179

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)

LONNIE PHILLIPS
Employee/Petitioner

v.

ILLINOIS STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

Case # **17** WC **08105**

Consolidated cases: **17 WC 08104 & 17 WC 35924**

An *Application for Adjustment 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 **October 19, 2018, October 11, 2019 and November 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. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **March 14, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**Unknown**; the average weekly wage was $**1,270.80**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **0** dependent children.

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

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

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 his employment on March 14, 2017.

The Arbitrator finds that the Petitioner's left elbow condition is causally related to the March 14, 2017 accident. The Arbitrator further finds that the Petitioner has failed to prove that his lumbar condition is causally related to the March 14, 2017 accident.

The Arbitrator finds that the Petitioner has failed to prove that he is entitled to temporary total disability benefits related to the March 14, 2017 accident.

Respondent shall pay reasonable and necessary medical expenses related to the left elbow which were incurred between March 14, 2017 and April 13, 2017, as provided in Sections 8(a) and 8.2 of the Act. Medical expenses related to the lumbar spine and left wrist are denied, and medical expenses related to the left elbow after 4/13/17 are denied.

The Arbitrator finds that the Petitioner's lumbar surgery is not causally related to the March 14, 2017 accident, and Petitioner's request for prospective medical treatment is denied.

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

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

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

however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

April 20, 2020
Date

APR 3 0 2020

STATEMENT OF FACTS

Petitioner testified he has been employed by Respondent as an Equipment Operator Laborer (EOL). Respondent's main office is in Downers Grove, but they have garages scattered throughout the system, and Petitioner's was located at I-294 and Cermak Road, Maintenance Garage 2, in 2017. An 11-year employee, Petitioner testified he is left hand dominant, and that he has lived in Lisle, Illinois since 2016. The job involves a variety of road-related activities, including concrete / pavement demolition and repair, guardrail repair, cleaning up after vehicle accidents, plowing snow, fixing drainage appurtenances, cutting grass, driving tractors, graffiti removal, cutting trees and brush and driving a street sweeper. Physically, Petitioner testified he would lift from things ranging from a two-pound hammer to a 90-pound bag of cement mix. He indicated there are things that are heavier that he has not personally weighed, such as a 25' piece of guard rail, a tow behind water pump, snowplow blades, spreader boxes for salt, etc. He testified he also has to shovel asphalt and concrete sand.

Petitioner testified he worked 40 hours per week dayshift from 7 a.m. to 3 p.m., Saturday through Wednesdays with Thursday and Fridays off, in early 2017. He would also get overtime, particularly with snow plowing or accident clean up. He would generally work the roads between O'Hare Airport and I-55, which he indicated has lots of interchanges and accidents. Overtime is mandatory in winter, and he estimated he would average 200 hours of overtime during the winter. He would drive a variety of vehicles, anything from pickup trucks to dump/plow trucks, sometimes with large plows. Petitioner testified that his duties would change day to day. He would go to the maintenance garage in the morning to attend a daily meeting and to get his assignment for the day. He and his co-workers would generally work in teams. Petitioner testified his main job was setting up lane closures, along with performing repairs. Petitioner testified that the truck is cramped to drive and can be very bouncy with snow plowing, especially if you do not know the road areas where the plow might catch. In order to cut trees or bushes he would use chain saws, hedge trimmers, lawnmowers and weed whippers. Normally he takes breaks during his shifts, but he noted it is hard to take breaks during snow plowing.

Petitioner testified that weekend assignments are given on Fridays, as there are no weekend meetings, and he had been assigned to work on 2/5/17, a weekend date (and the subject of case 17 WC 35924), cutting trees and brush from sound/noise walls along I-294. He testified he was working with co-workers Erv Quinones and Greg Arredia and he was operating an 18" chain saw. He testified that he did this work for .5 to 1 mile near the Ogden and Hinsdale Oasis Northbound wall from approximately 8 a.m. to 10 a.m. He testified he became uncomfortable from carrying the 20-pound saw while hunched over and had severe pain in his back bilaterally at the belt line when he tried to stand up straight. He let his co-workers know he was going to the truck to rest, and when they came to the truck, he indicated he was having pain and was walking like another co-worker who walks hunched over. Petitioner testified he has had prior low back pain but had no such pain when he reported to work that day. When he didn't improve during lunch break, he called his boss, Phil Cassman, and told him what happened. Petitioner testified that Cassman advised him to contact Corvel to make a report and to take it

easy and to wash trucks that day. Petitioner testified that he did not seek treatment. He testified he didn't complete an accident report for Respondent until the following Monday (Px2), because supervisors aren't in the office/garage on weekends and he "didn't think it was too serious." Petitioner spoke to either Cassman or Don Ryan, the other supervisor at the garage, on 2/6/17. When he spoke to Corvel, Petitioner didn't indicate he needed treatment, and the Corvel nurse advised him to use ibuprofen and ice for a couple days and to call back to obtain treatment if he didn't improve. He continued to work through the following Wednesday but didn't improve so he again contacted Corvel that Thursday. Treatment wasn't approved at Petitioner's choice of the Back Institute, and he testified he was only approved to see Dr. Bicek.

Petitioner saw Dr. Bicek on 2/14/17 and reported the following history: "States he was using a chainsaw cutting trees along the tollway at work on 5 February for about hour to 2. He then started having low back pain. He was told to take it easy and wash the trucks the rest of the day. He continued to go to work. Wednesday 3 days later he had more lower back pain. This has persisted. It's worse when he wakes up maybe 5/10. It gets better 2-3/10 during the day." He denied leg pain, numbness or weakness. Petitioner indicated he did not want to be on light duty at work. Acute low back pain without sciatica was diagnosed and he was prescribed Naproxen and advised to rest. The Arbitrator did not note any statements regarding Petitioner's work status. (Px9A). Petitioner testified that Dr. Bicek prescribed physical therapy and home exercises, that therapy wasn't approved and that he didn't return to see Dr. Bicek. He continued to work full duty, acknowledging he requested a release to return to full duty.

On 2/27/17 (the subject of case number 17 WC 08104), Petitioner testified he was assigned to operate a street sweeper. While driving back to the garage to dump his full load, at highway speed, he hit a pothole or defect in the road, lifting him off the seat and striking his head on the roof. He testified he felt back pain at that time and reported the incident to either Cassman or Ryan. He again was advised to contact Corvel, which he did, and was referred to the company clinic.

At Advocate Occupational Health on 2/27/17, Dr. Hyre recorded that Petitioner was driving a street sweeper that day, hit a large pothole and came down hard on a rigid seat, injuring his lower back. There were no neurologic symptoms. Petitioner reported a prior history of herniated discs. Dr. Hyre prescribed a Medrol dosepak and released Petitioner to return to regular work duties "Per pt request", noting Petitioner was "refusing any work restrictions." The discharge states: "Follow up with Illinois Back Institute per your request." (Px10). Petitioner testified he believed he and Dr. Hyre discussed his job duties and what type of work he was going to be returning to, as well as that he had a preexisting back condition going back to 2012. He again acknowledged he didn't want to be off work and asked her to return him to regular duty, which he did the next day, 2/28/17.

Petitioner testified he was feeling "about 90%" at work on 2/28/17. He was assigned that day to use an air hammer to break out collapsed drains on the side of the road, remove the concrete and then pour new concrete. Concrete preparation involves mixing a 90-pound bag of cement mix, 15 shovels of gravel and 15 shovels of sand. He estimated he had to move about 5 tons of broken concrete that day, and that he "also" bumped into the truck a couple of times, injuring his left elbow. He recalled using approximately 10 bags of concrete. Two coworkers were using the shovels. He also was asked to help two other workers to remove broken up concrete, testifying they filled the back of a pick-up truck about 3' above the truck sides. He testified that towards the end of the shift he bumped his left elbow. Believing he hit his funny bone, he shook it off and went back to work. When he later removed his long sleeves, he noticed that his elbow was swollen. He had a pre-planned day off the next day and his regularly scheduled two off days off after that. He called Corvel and was sent back to Advocate Occupational Health.

Petitioner returned to Dr. Hyre on 2/28/17 (4:59 p.m.), this time reporting swelling and moderate pain at the left elbow: "I was doing a lot of heavy construction today, I struck my left elbow several times and I now have pain

and swelling of my elbow." There was pain and swelling at the olecranon bursa. There was no abrasion or bruising. Diagnosis was left olecranon bursitis. An x-ray was offered but Petitioner wanted to follow up with his own ortho for this, so he was referred there for further treatment, with Dr. Hyre indicating "urgent ortho consultation." A left elbow sleeve was provided, and Petitioner again refused work restrictions. (Px10). Petitioner testified that he was sent to Edward Hospital for an x-ray and he requested a full duty release to return to work.

Petitioner went to the Edward Hospital emergency room at 6:47 p.m. on 2/28/17 reporting a left elbow injury: "He was throwing large concrete blocks into the back of a pickup truck for work today when he struck his elbow on the edge of the truck. He noted some increased swelling to the electron area today. Minimal pain." A separate note indicated he hit the elbow on the truck around noon. At this facility. X-rays showed olecranon bursa swelling, slight triceps enthesopathy and no acute fracture or other acute abnormality. Diagnosis was posttraumatic olecranon bursitis. Petitioner was offered an Ace wrap but preferred to use his own splint. He was advised to follow up with his primary provider. (Px11).

Petitioner testified he continued to work regular duty through 3/14/17. On that date (the subject of case number 17 WC 08105), it was snowing and he was assigned to a plow truck driving between Cermak Road and I-90 on I-294. He came back to the garage to load salt and fuel the truck, parking outside of the garage to use the restroom. Petitioner testified it was wet and snowy outside, including in the parking lot, at the salt dome or at the gas pumps. Trucks pulling in and out made the garage area wet as well. He testified he was wearing work boots that day (see Px26) and that they were very wet when he came into the office building through the garage door. He testified he also had a snow suit on that was wet at the bottom of the pants as well. He testified he walked between 50 and 150 feet to the garage area. He testified that as he went to go upstairs to the second-floor locker room bathroom he slipped and fell.

A photo (Px2) depicts a view going from the garage into office area. The floor inside the office area is marble. There is an area depicted, the "Time clock area", where there is a bulletin board. Petitioner was planning to go up the depicted stairs to the locker room. Petitioner testified this photo was taken after the alleged accident date but testified that the lighting and dimensions shown in the photo are the same as they were on the accident date. In the room when he entered from the garage were co-workers Nick Berardi and Lorenzo Slack, who were talking near the time clock. Mr. Slack was a relatively new employee at that time, maybe 2 to 3 months. Petitioner walked by them to go up the stairs. He testified he asked if they were clocking out, but he was not sure if they heard him as they didn't acknowledge him. As he went to step on the first stair, he testified he caught it with the toe of his boot, and as he went to go to the second step, the toe of his other boot slipped off the first step and he fell forward onto the stairs, landing on his left elbow and left side. After cursing, he got up and went upstairs. He went to supervisor Don Ryan's office on the second floor and reported he had fallen on the stairs and had severe elbow pain. Petitioner testified that Ryan slammed the door in his face. Confused, he waited for a bit to see if he was coming out or not. After a few minutes Ryan came out, walked past him without saying anything, and took a camera and started taking pictures of the stairs. Petitioner followed him down the stairs. They didn't speak further. Petitioner noted he started taking pictures himself when he didn't think Ryan was taking pictures in the right spot. When they then went back upstairs, Petitioner indicated he had slipped up the stairs, as his boots were wet and there was some water on the stairs. He testified he indicated his boot prints were there. He testified that Ryan then advised him to call Corvel.

Petitioner identified Px3 as a photo he took at approximately 11:57 a.m., which was about five minutes after he first reported the incident to Ryan. He testified that the marks on the floor in the photo are from his boot prints, which showed the path he walked. Petitioner testified he stepped up on the stairs with his left foot, toe on the edge of the step, went to push off to put his right foot on the next step and his left toe slipped off. He testified that he may have asked Berardi and Slack if they saw what happened, but he didn't stop to talk to them. He

didn't think they were still present there when he went to take the photos, and he indicated he hadn't told them anything about the injury or what happened.

Philip Cassman testified that he works as a maintenance section supervisor for Respondent, and that he was the Petitioner's immediate supervisor working out of Maintenance facility 2 in Hillside in 2017. Don Ryan was the manager of the maintenance facility. Cassman testified his duties include giving out daily job assignments, following up on them and dealing with safety issues. Mr. Cassman was aware of Petitioner's three pending workers' compensation claims. On 2/27/17, Petitioner came into the office and reported he hurt his back working on the sweeper. He had assigned Petitioner to a road shoulder sweeping job in the number 259 sweeper, and the Petitioner reported hurting his back when he hit a pothole. He gave the Petitioner injury reporting paperwork and advised him to call Corvel. Petitioner had already spoken to Corvel because they had canceled a previously scheduled doctor's appointment that he was supposed to have later that day related to a prior back claim. He then advised Don Ryan that Petitioner reported hurting his back. He then went down to inspect the sweeper, including the seat and tires, and it was operating properly. He testified the machine had an Air Ride seat, which provides a smoother ride. Cassman testified he went with mechanic Jim Murphy to look at the sweeper to make sure the air ride seat was working and that it didn't leak air, and there were no air leaks found. He also testified that in the two years between March 2015 and March 2017, no one had ever complained about problems with the seat in #259. The machine is serviced every 100 hours of use by going through a checklist. He further testified that if the machine breaks down it would be brought in to be fixed, and while he acknowledged that #259 was in the shop quite a bit for mechanical problems, this involved mostly conveyor or broom issues. He doesn't review the repair sheets himself; he is informed of what the problems are by the mechanic. He had no knowledge of physical maintenance records and he could not say how old the machine was in 2017. Mr. Cassman testified didn't spend a lot of time on the machine but has driven #259 himself when he initially was promoted to supervisor in 2015 and it was working fine and did not involve a bumpy ride in his experience. As to the 3/14/17 incident, his understanding is Petitioner was hurt entering the stairway in the building. He verified that Mr. Slack and Mr. Berardi were also EOLs for Respondent, and that there is a time clock in the office building stairwell where employees have to use a badge and fingerprint to punch in and out. On cross-examination, Mr. Cassman testified he had not driven sweeper #259 again after March 2015, at which time it was working fine.

Donald Ryan, Respondent's Section Manager for the Tollway since 2011, testified that he oversees and manages an assigned maintenance facility, currently at the Arlington Heights facility but in 2017 was at the Hillside location, Number 2, and Petitioner was one of his employees there. He gives out the daily assignments to the day shift workers, does other paperwork and goes out on the road to check up on work crews and to look for roadway deficiencies. Mr. Ryan testified that as section supervisor, Mr. Cassman was basically his assistant but that they are more or less equals with the same responsibilities and coordinate with each other on what they are going to do. Mr. Ryan verified his office is on the second floor of a two-level building where the first floor is a hall to the upstairs and the garage where mechanics and trucks are. His office can be accessed from the west side, between a wall and the building, and on the north side by walking through the garage, into the hallway near the time clock and up the stairs.

On 3/14/17, Mr. Ryan acknowledged that there had been a two day show and ice event and the workers were out plowing snow. Sometime around noon the Petitioner came in and advised that he had slipped and tripped up the stairs and hurt his elbow. Someone was present at a table in the common area outside of his office, but Ryan could not recall who it was. He told the Petitioner he thought he had previously hurt the elbow and that Petitioner said he reaggravated it. Mr. Ryan advised Petitioner to contact Corvel. He then got paperwork for Petitioner to complete and testified the Petitioner went to the conference table in the common area while Ryan went to the stairs to take photos of them near the office door, at the landing, and at the bottom of the stairs, which he identified as Rx7. He then went back into his office, closed his door and made the necessary phone

calls he needed to make. He testified he took the photos with his cell phone, not a camera, noting the facility got rid of cameras once cell phones were readily available for any needed photos. He estimated he took the photos about 5 to 10 minutes after Petitioner reported the incident. Mr. Ryan could not recall any specifics of where the Petitioner fell on the stairs and didn't recall the Petitioner ever saying where exactly where he fell, all he recalled is that he tripped up the stairs.

Mr. Ryan testified that he summarized what occurred and agreed there are references to water. He acknowledged that there was snow and ice outside that day and there was some water from the door of the garage in the area of the timeclock, but he did not see any water in the area at the bottom of the staircase. He testified that he didn't see the Petitioner near the stairs when he was talking the photos and didn't see the Petitioner take any of his own photos. Mr. Ryan testified that the floor is terrazzo at the base of the stairs and the stairs themselves are concrete, which are less slippery than the terrazzo floor. He testified that he had not seen Petitioner's photo of the stairs prior to the hearing date, and indicated he did not see the alleged boot marks on the floor at the bottom of the stairs when he was taking photos, just the wear on the floor, and he verified the photos he took accurately depicted the condition of the stairs that day.

Mr. Ryan agreed that Petitioner would have been plowing snow that day and there would have been a number of reasons he might have needed to be outside of the truck that day. Most employees park between the salt dome and building on the north side when they come inside, which he indicated this would be anywhere from 20' to 30' away from the building, while it could be 5' to 10' if you park next to the building. Mr. Ryan testified the Petitioner did not say anything about injuring his back that day and did not initially indicate there were witnesses. After Petitioner went to the company clinic he returned to the office and he and Ryan briefly spoke again, including about Mr. Berardi and Mr. Slack being witnesses, and Petitioner then provided his written statement, listing Berardi and Slack as witnesses. Mr. Ryan did not recall seeing either of them downstairs when he was taking the photos. The next day he testified he approached Berardi and Slack individually to ask what they were aware of, as they were busy on 3/14/17 plowing snow. The Petitioner provided his written statement, listing Berardi and Slack as witnesses. Mr. Ryan testified he regularly deals with workers' compensation claims, and when an injured employee indicates there were witnesses to an incident, he is required to obtain statements from them. He met with Mr. Berardi and Mr. Slack separately in his office between 7:00 and 7:30 a.m., advised them they had been listed as witnesses and that they needed to prepare statements about what they knew. Both of them indicated it was the first time they had heard about Petitioner claiming injury, and each of them completed their own statements (see Rx1 & Rx2). Once he gathers all pertinent information about a workers' compensation claim, Mr. Ryan provides that information to management.

On cross examination, Mr. Ryan testified that Petitioner reported slipping and tripping up the stairs and injuring his elbow, he did not report a back injury. He denied slamming the door in the Petitioner's face and denied being angry. He testified that after he gave the Petitioner the employee injury report packet to complete, Petitioner sat at the conference table in the common area and was completing the documents. He again testified that the Petitioner did not follow him down the stairs when he went to take photos. Mr. Ryan testified that the Petitioner completed an Employee Accident/Incident Report that day, 3/14/17. He testified that he completed the document in Px6 based on what the Petitioner told him. While Petitioner was supposed to complete it and sign it, Mr. Ryan testified he refused.

Mr. Ryan did acknowledge that he checked the box in the documentation indicating injury to the lower back on 3/15/17 but testified that he didn't recall what the Petitioner told him that day. The report states he slipped on some water at the stairs and said he hit his arm while falling or tripping on the stairs. He testified that Petitioner initially said he tripped on the stairs, said there was water in front of the stairs and that he slipped walking up the stairs going to the locker room. Mr. Ryan was not sure if or when he and the Petitioner had a second conversation on 3/15/17. He did witness Petitioner signing the document the next day. As to an indication of

striking an object, Mr. Ryan testified that he meant the stairs when he wrote this. Because Petitioner said he slipped on stairs, he took photos of the stairs. Mr. Ryan did not recall what boots or shoes the Petitioner was wearing. There is water on the floor in that area sometimes, and he testified that building maintenance or janitorial would clean the area, change carpets, etc.

When he was shown the photographs in Px4 & Px5, Nr. Ryan testified that the runner depicted was placed to collect water and dust. The orange cone exists to let people know its slick, noting that the terrazzo is slick when it gets wet. He testified that he would have expected Petitioner's boots to have been wet on 3/14/17. He took the photos in Rx7 between noon and 12:15 p.m. He did say there was water from boot prints in the hallway. While he didn't see the Petitioner do so, he agreed he may have gone down and took photos himself. He agreed the photo in Px3, with an 11:57 a.m. time stamp, depicts marks before the stairs

Mr. Ryan indicated on redirect exam that he may have obtained more information from the Petitioner the day after the alleged accident. He reiterated that the written statement from 3/14/17, Rx6, was completed by Petitioner in his own handwriting, and it indicates he slipped on water and hit his elbow on the stairs with no mention of the low back.

The Arbitrator notes that the photos in Px2, Px4 and Px5 depict the Respondent's office building's lower level. The area is essentially a long room, with swinging glass doors in the front and the gray steel door testified to by the witnesses at the other end. There is a large bulletin board on the wall in the hallway between them, and the board faces the stairwell. As testified to, the floor does appear to be terrazzo and the stairs do appear to be concrete and metal with a solid metal railing. Px3 is a photograph Petitioner identified as one he took on 3/14/17 of the area at the bottom of the stairs. The Arbitrator notes that there are patches of dirty areas at the bottom of the stairs that appear to have been made with shoe wear. The photo is from a cell phone, was taken by someone from a position on the stairs themselves. (Px2 through 5)

Px26 contains side and bottom photos of the Petitioner's boots from the alleged accident date. These photos were purported to show a unique tread on the Petitioner's boots that could somehow be seen in the photos the Petitioner took. However, the only photo that allegedly depicts the marks on 3/14/17 that is in evidence is Px3, and there is no way the Arbitrator can tell whether the marks on the floor were made by any specific boot tread. Petitioner testified that the photograph in Px3 depicts his footprints walking in a semicircle around the railing, and the Arbitrator notes that the location of the marks could be from someone walking from the hallway around the railing and to the stairs.

The Arbitrator does take note that the photos in Px4 and 5, which Petitioner testified were taken by him sometime between September 2017 and May 2018, shows that a carpet runner had been placed in the hallway between the front and gray garage doors, as well as in front of the stairs along with an orange cone. Petitioner testified the cones and the carpet were not present on the alleged accident date and were put in after his injury. The Arbitrator notes that remediation measures that may be taken by a Respondent does not confer liability on them under the Act. However, the Arbitrator does take note of the photos for whatever evidence they may provide with regard to evidence of notice to Respondent.

The Arbitrator also notes that the photo in Px2 appears to have been taken on a day different from both the alleged accident date and the time the photos in Px4 and Px5 were taken, as no carpets were present in the lower level. This photo does depict an "LS" mark that indicates where Mr. Berardi and Mr. Slack were standing at the time of the alleged accident, in front of the bulletin board. The Arbitrator would note that where they were standing appears to be within 5 feet, to 10 feet at the most, from the stairwell, and there would be nothing obstructing their view of the stairs had they been looking at the stairs.

The photographs taken by Don Ryan were also admitted into evidence (Rx7). This includes pictures of the floor and bottom stair, the landing of the stairs, and the floor at the top of the stairs just outside the offices. The Arbitrator notes that the floor at the bottom of the stairs was quite dirty and appears to be dry, but also acknowledges that this is very difficult to perceive by simply looking at the photos. (Rx7). The Arbitrator would also note that the area photographed by Mr. Ryan is directly at the bottom of the steps and includes the bottom stair, while the Petitioner's photo shows mainly the area just beyond the bottom of the steps towards the glass doors.

The witness statements of Nick Berardi and Lorenz Slack were submitted into evidence. Both statements are dated 3/15/17. Mr. Berardi indicated he did not directly witness Petitioner's accident, and that he was first made aware of the incident "Just now at 7:30 on 3/15/17." (Rx1). Mr. Slack also indicated he did not directly witness an accident, and "Was first made aware when called into the office to ask if I saw it at 7:30 a.m. 3/15/17. (Rx2).

Lorenz Slack testified he began working for Respondent on 1/3/16 as an Equipment Operating Laborer (EOL), with similar duties as Petitioner, but he was still a hands-on trainee. He recalled he was standing in front of the bulletin board near the time clock (see "LS" on Px2) talking to Berardi sometime between 2:40 and 2:45 p.m., as he punched out at 3 p.m. on the dot. They had worked together that day and were talking about something they were looking at on the bulletin board. His back was to the stairs when he peripherally saw the Petitioner walk in through the gray door from the garage. He did not if Petitioner said anything or not. While he was still facing the board, he heard a yell and a kind of foot slap sound. He turned around and saw the Petitioner sitting on the stairs with his elbow on the rail pulling himself up. He testified he was on the first or second stair. He testified he did not see any actual incident and did not see the Petitioner fall. When he heard the sound, he turned around and thought the Petitioner had been joking around. He testified the Petitioner asked, "Did you see that?" Berardi asked him if he was alright, Petitioner didn't respond and he went up the stairs.

The next day, Mr. Slack testified that Ryan and Sweeney pulled him into the office to ask about Petitioner. He testified he initially didn't know what they were talking about, and they told him Petitioner hurt himself and said Slack saw him fall down the stairs. He told them he didn't know what Petitioner was talking about and didn't know he was hurt, as he thought the Petitioner had been joking around and he had no idea anything was going on. Ryan asked him to then just then write that he didn't see anything, which he did (Rx2). Mr. Slack testified that he and the Petitioner are both musicians and have worked together a couple times. They weren't close friends, but they would talk outside of work about music a lot.

Cross-examined by Respondent, Mr. Slack verified that the incident had to have occurred sometime between 2:45 and 3 p.m., as that's the only time he would have been in that area. He testified he was in that area for about 15 minutes after washing trucks outside and changing blades on the plow. He denied that this could have been around noon as he never punches out that early. He did not recall seeing anyone's footprints. At that time, he testified a shift would all be punching out, which he estimated would be 12 to 15 guys. They would go to the locker room upstairs to change then come back and sit down until 3 p.m. He acknowledged receiving a text from Petitioner 2 or 3 weeks before his testimony indicating his attorney would be contacting him, and that he hasn't had any discussion with anyone else since that time. He only discussed what had transpired at work with Petitioner's attorney the day of the hearing.

Slack testified that guys in the garage joke around with each other a lot and he reiterated that when Petitioner didn't respond to Berardi asking if he was okay, he assumed Petitioner was joking around. He believed the Petitioner was using his left arm to pull himself up. He estimated he was approximately two to four feet away from Petitioner when he heard a thud and a yell, and he turned around a second later. He was told the next morning by Ryan and Sweeney that Petitioner said he fell on the stairs, and he told Ryan he didn't initially

know what he was talking about because he thought Petitioner was joking, but that he heard Petitioner yell, saw him on the stairs, asked if he was okay and Petitioner walked up the stairs.

Nick Berardi, also an ELO for Respondent, testified that he had been off work since 4/23/18 himself due to his own work injury. He has worked together with Petitioner often and testified they shared the same basic job duties. They would work in teams and would all contribute to jobs, and he indicated the Petitioner performed well on the job. He described the areas upstairs and downstairs in the office building as depicted in Px2. Berardi testified he did not recall what the Petitioner's assigned job was on 3/14/17. He saw him at the morning meeting but did not work with him that day. He verified that it was cold and wet that day and that his boots and pants got wet. Sometime between approximately noon and 12:15 p.m. that day he testified he was talking to Mr. Slack, who he worked with that day, and they were looking at something on and facing the bulletin board. He noticed the Petitioner walk in from the garage, they said hello to each other, and he went back to talking to Slack. He testified he then heard a thud, turned and saw that Petitioner appeared to be in the motion of getting up on the stairs. He asked the Petitioner if he was okay, but the Petitioner didn't answer him or say anything more and continued up the stairs. He testified that the thud sounded like someone fell and hit the pavement, causing him to turn around. He saw the Petitioner getting up from laying on the stairs, recover his stability and then walk up. He testified that the floor is slick when work boots are wet.

Berardi testified he was first made aware that Petitioner had an accident and said he got hurt following the morning meeting on 3/15/17. Foreman Don Ryan asked he and Slack to come into the office to prepare a report, indicating he said they were witnesses to him falling on the stairs. Berardi asked if they meant from the day before and they said yes. He agreed he completed Rx1 in his handwriting on 3/15. He reiterated he heard the thud and saw Petitioner getting up from the stairs but didn't know he had been injured at that time. Mr. Berardi verified that the rugs depicted in Px5 were in the building in March of 2018, and he acknowledged that the floor and stairs can be slippery in the building, noting hard toe shoes are required for the job.

On cross, Berardi testified he was working with agreed that while he normally punches out at 3 p.m., he was in the office building at noon because they must have been taking a break. He acknowledged that he and Petitioner became work friends and they would joke around a lot. The bulletin board was about four feet away from where Petitioner was on the stairs and he turned around immediately when he heard the thud. Petitioner was in a prone position when he turned around, lying on his stomach up the stairs. He verified that he prepared Rx1 after being told Petitioner reported falling on the stairs and that he witnessed it. He indicated he didn't witness an injury because he didn't visibly see him fall since his back was turned. He indicated he was made aware of the accident/incident "just now" because he didn't realize Petitioner had been injured. When he had asked Petitioner if he was okay, he didn't say anything, and after collecting himself for a second or two he continued up the stairs. He did not notice Petitioner holding his elbow, but he was looking to see if he hit his head and didn't focus on anything else.

Petitioner testified he was again sent to Advocate by Corvel, and he again saw Dr. Hyre. An initial injury report at Advocate Occupational on 3/14/17 (12:40 p.m.) notes: "Slipped and fell on stairs hitting elbow hard." The progress note states: "According to the pt, while at work, he was in a stairwell talking to coworkers when he slipped on water, fell, and landed on his left elbow. He reports pain and swelling in the left elbow. He does have a previous injury to that left elbow about a few weeks ago and the swelling has been there since that injury. The swelling never subsided from that injury and now he reinjured the left elbow when he fell today." Left elbow x-ray showed an ossific density at the dorsal aspect of the olecranon process with associated soft tissue swelling, concerning for an avulsion fracture. Correlation with point tenderness was recommended. Diagnosis was left elbow contusion, and an avulsion fracture of the olecranon process. Petitioner was restricted from left arm use and referred for orthopedic evaluation. (Px10; Rx4).

Petitioner testified he reported both elbow and back pain at Advocate. Petitioner acknowledged that he only reported elbow pain to supervisor Ryan on 3/14/17 because he had a lot of elbow pain. He testified that by the time he left the clinic the supervisors had gone for the day so he couldn't complete injury paperwork. Petitioner testified that after being diagnosed with an avulsion fracture the doctor was going to schedule him with an orthopedic surgeon.

On 3/15/17, Petitioner went to the garage at 6:30 am and dictated an accident report to Supervisor Ryan, indicating that he hurt his elbow and low back. Respondent submitted a one-page document into evidence, dated 3/14/17, alleged to have been signed by Petitioner, which states only the following: "Slipped on water at bottom of stairs. Fell & struck left elbow on stairs." (Rx6). Petitioner testified he also completed an Employee Accident/Incident Report Form (Px6) on 3/15/17 where he also indicated back symptoms.

Petitioner testified the 3/15/17 (Px6) was filled out by Don Ryan and that Petitioner then signed it. The Arbitrator notes this document indicates the Petitioner reported an incident occurring at the garage on 3/14/17 at 11:45 a.m. and that it was reported around noon. The document further indicated that he injured the left elbow and low back due to a fall and striking against an object. These are noted via check marks to injury types that are already noted. The incident is described as "coming upstairs to go to locker room", and that he slipped on some water "at or in front of stairs." Berardi and Slack were indicated as witnesses. It also notes the injury was immediately reported to the supervisor. It is signed by Petitioner on 3/15/17 and Mr. Ryan signed off indicating he witnessed the signature. (Px6).

Petitioner testified that when an orthopedic visit had not yet been scheduled for him, on 3/16/17 he contacted an attorney. On 3/16/17, Petitioner saw Dr. Tu at G&T Orthopedics for left elbow swelling following a work injury. Petitioner was noted to be left-handed. He reported that on 2/28/17 he was doing concrete work when the back of his elbow hit a concrete truck. When he later took off his sweater, he noticed the elbow was swollen. He noted he went to Edward Hospital for x-rays when occupational health did not have an x-ray available. Petitioner reported he then returned to regular duty until 3/14/17, when he tripped on some stairs and struck his left elbow. It was noted he was "diagnosed with an avulsion fracture, also started complaining of back pain. Since his recent injury, he has some swelling in the back of his elbow, does not have really any significant pain. He does have lower back pain." Dr. Tu diagnosed traumatic left olecranon bursitis and lower back pain. Dr. Tu opined that the direct trauma to the posterior elbow was a significant contributing factor to the development of the condition. The bursa was aspirated, and the elbow was compression-wrapped. He was released to full duties and advised to use an elbow pad. He was referred to neurosurgeon Dr. Salehi for the low back. (Px12). After draining his elbow, Petitioner testified that Dr. Tu recommended an elbow pad and felt he didn't need surgery. Petitioner testified on 10/11/19 that his elbow was fine and he was having no problems with it.

Petitioner initially saw Dr. Salehi on 3/23/17. Petitioner reported on 3/14/17 he fell down some stairs at work and since that time had left elbow and low back pain. He denied pain or numbness radiating to the legs. He was working full duty. Petitioner acknowledged that he was hit by a car at work many years prior, had low back pain, three months of therapy and was "then told to return to work. He stated that since that time he had some low-grade back pain but that it was never to the degree that it is currently." Physical therapy and lumbar MRI were prescribed. (Px9B; Px13A).

On 4/13/17, Petitioner returned to Dr. Tu. He reported his elbow symptoms had improved with aspiration but that about a week after his original work injury he started to get left wrist pain: "He feels that it was after a fall at work since his injury, he has difficulty with extension of the wrist." Dr. Tu diagnosed a possible triangular fibrocartilage complex (TFCC) tear and ordered a left wrist MRI. He was allowed to continue regular duty. (Px12).

Lumbar MRI films obtained on 4/19/17 indicated mild loss of intervertebral disc space height and loss of normal T2 hyperintensity of the disc material with a small posterior broad-based disc protrusion. There was minimal associated central stenosis and foraminal narrowing. (Px9B; Px13A; Px14).

On 5/2/17, Petitioner reported 2-3/10 low back pain at rest that could go up to 7/10 with work activities. He denied radiation of pain. Dr. Salehi noted single level degeneration at L4/5 with a small paracentral and right disc bulge. He indicated Petitioner had low back pain secondary to aggravation of L4/5 disc disease/annular tear and recommended physical therapy, noting Petitioner could be a fusion candidate in the future if his symptoms persisted. Mobic was also prescribed. (Px9B; Px13A).

On 5/4/17, Dr. Tu indicated Petitioner reported continued difficulty with full wrist extension and that they were still awaiting MRI authorization. (Px12).

When Petitioner followed up on 5/30/17, he reported no low back improvement with therapy, which is consistent with his testimony. Dr. Salehi continued to advise therapy and allowed Petitioner to continue to work full duty. On 6/20/17, Petitioner reported his low back pain was mild, but he lifted something heavy at work on 6/11/17, aggravated the pain to where it was hard to move and took a couple sick days until he returned to a baseline level. He continued to deny radiation. Noting the pain could be due to L4/5 or possibly also the SI joints, Dr. Salehi prescribed diagnostic and therapeutic SI joint injections along with ongoing therapy and continued him on regular duty. (Px9B; Px13A).

On 7/13/17, Petitioner saw Dr. Farag at Midwest Anesthesia and Pain Specialists based on the SI joint injection recommendation. Petitioner reported his elbow problem had mostly resolved but was still sore from time to time. The back pain was mostly left-sided, occasionally right-sided, with occasional pain down the leg to the knee if the back was palpated firmly by the physical therapist. Petitioner reported the pain made work difficult and that he wasn't playing as much golf as he used to, his favorite pastime. He had been working unrestricted in what Petitioner described as a heavy job and "he prefers to continue working without restrictions." Dr. Farag recommended the SI injections, a back brace, physical therapy, NSAID cream and lidocaine patches. (Px16).

On 7/25/17, Dr. Salehi noted continued left low back complaints with increased intensity based on work activities. He indicated "when the pain is significant it will radiate down the left leg otherwise he denies any radiating leg pain or paresthesias." It would occasionally radiate to the right low back. He was to undergo SI joint injections on 8/3/17 and continue regular duty. On 8/21/17, Petitioner denied pain radiating into the legs. At this point Dr. Salehi stated that the Petitioner was not working because his restrictions were not being accommodated, and that he "continued" to recommend L4/5 fusion surgery. He was advised to stop smoking and to continue on light duty status. (Px9B; Px13A). The Arbitrator notes that no records were submitted prior to this visit which reflect light duty restrictions or a specific surgical recommendation.

On 8/3/17, Dr. Farag repeated his 7/13/17 recommendations. (Px16). On 8/18/17, Petitioner saw family physician Dr. Wojcik, who noted he injured his back when he fell down stairs at work in March and was there for a note indicating he was limited to certain work duties because he had been using vacation and sick time and he had no more vacation time left to use until 9/21/17. He noted he was waiting for Respondent to authorize the SI injection. Tramadol helped but he couldn't take it at work because it made him feel high. (Px9A).

Petitioner testified that Dr. Wojcik restricted his driving and operation of heavy machinery, not physical activities, and that Respondent could not accommodate this. Petitioner testified that when Dr. Wojcik gave him work restrictions from 8/19: "I asked for September 20th because that's my anniversary date, and I would get three more weeks (of) vacation. So I was hoping that if the injections still weren't approved by then, I can at least get back on the clock and ease through my vacation time to get the restrictions, but then I got the injection,

part of that. The injection didn't work." He testified he gave an 8/18/17 note reflecting this restriction to Don Ryan on 8/18/17 or 8/19/17, and that Ryan told him he would have to call his boss about it. On 8/19 or 8/20/17, he received a call indicating the Respondent could not accommodate the restrictions and he was then off work. Petitioner testified he had different counsel when Dr. Farag had prescribed the injection and back brace, which was never approved. The injections weren't performed until August and September. Petitioner denied being told why Respondent would not authorize these prescriptions. He had continued to work regular duty from March through 8/14/17.

On 8/29/17, Dr. Farag performed left SI joint injection. (Px16). It appears that Petitioner attended therapy at ATI from 5/10/17 through 9/13/17, at which point the therapist indicated Petitioner had reached maximum medical improvement (MMI) with regard to therapy as he had plateaued without meeting almost any of the planned short or long term goals. (Px9B; Px13A; Px15).

On 9/19/17, Petitioner told Dr. Salehi the SI joint injection did not help. The report states: "He was given Tramadol for pain about a month ago and since then has been off work as he is not able to drive." Left low back pain with occasional tingling in the left buttock was reported. Given no relief with the injection, Dr. Salehi opined the pain was most likely related to the L4/5 condition. He was changed from Tramadol to Celebrex and given light duty restrictions (no lifting over 20 pounds, no push/pulling over 35 pounds, no bending or twisting), including no driving of a company vehicle. It was noted he would follow up in 4 weeks and be released to full duty. (Px9B; Px13A).

Petitioner testified that Dr. Farag had provided him with Tramadol at his office, and while it helped his back pain, it made him feel kind of "loopy", which he couldn't have while operating commercial machines at work, so he had to take days off while he was waiting for the injection to be approved to avoid driving under the influence. He testified he was told he could no longer take vacation days off for this alleged injury after 8/14/17. Therefore, if he worked regular duty and hurt someone he would have to take a drug test, and he testified he didn't want Respondent to take on that liability. On cross exam, he testified that he continued to drive his car and could not recall if the medication impacted his personal driving. He noted that a CDL license has a higher standard than a regular driver's license.

Petitioner testified that Dr. Salehi indicated his bills weren't being paid by Respondent, and that his prior attorney hadn't informed him that his claim was being denied. He would call his boss every or every other week to report that he still had restrictions. Petitioner testified his understanding of Respondent's policy is that he would need a full release before he could return to work, and this was what Don Ryan told him in August after getting his work restrictions. At some point a Mr. Sweeney became the new section supervisor below Ryan and that is who the Petitioner would talk to weekly or biweekly in August and September to indicate he still had restrictions. Petitioner testified therapy at ATI wasn't helping after 4 months, and neither did the injection, so more aggressive treatments were planned. He had expected he would receive TTD when he went off work on 8/15/17 since Respondent was paying for therapy.

On 9/26/17, Petitioner returned to Dr. Farag and indicated he didn't think the injection helped very much after having 75% improvement the day of the injection. He was taking Tramadol but hadn't tried lidocaine patches. (Px16).

On 10/17/17, Dr. Salehi reviewed a 9/6/12 MRI ("disc disease at L4/5 with mild height loss and small central herniated disc") and compared it to the 4/19/17 films, indicating they showed further loss of T2 signal of the L4/5 disc. Light duty was continued and he was to return following a court date to determine if he would proceed with treatment of obtain a functional capacity evaluation (FCE). On 11/14/17, Dr. Salehi stated that Petitioner "may be a candidate for a lumbar fusion should his pain become unbearable." Light duty restrictions

were continued. (Px9B; Px13A). Petitioner testified when fusion was discussed at this point, he was basically sedentary.

On 1/2/18, Petitioner reported continued left low back pain that was worsening with radiation into the legs about once a week. He was not working as light duty was not being accommodated. Dr. Salehi indicated the pain was due to L4/5 disc disease/annular tear, and given the pain was becoming intolerable he recommended an L4/5 decompression and fusion surgery. Petitioner reported he had quit smoking and would need to continue that for at least 9 months post-surgery. Restrictions were continued. Surgery and light duty were again continued on 2/6/18 while awaiting authorization. Restrictions were again continued on 8/21/18. (Px9B; Px13A).

Dr. Salehi testified via deposition on 6/26/18. He first saw the Petitioner on 3/23/17 on referral from Dr. Tu for the low back, as Dr. Tu is not a spine surgeon. The Petitioner reported his alleged 3/14/17 work accident and "a chronic history of lower back pain, but he called it low-grade pain prior to this injury", which Petitioner indicated went back to when he was struck by a car at work. Petitioner indicated on 3/14/17 that he "fell at work down the stairs, injuring his elbow and low back." Dr. Salehi testified he determined that Petitioner was a lumbar fusion candidate. He testified that 80% to 90% of patients with low back pain due to degenerative disease get better with conservative care and time, but they become fusion candidates if they don't get better and remain in moderate to significant pain. He testified that Petitioner's 2017 lumbar MRI showed an L4/5 annular tear causing mechanical back pain and conditions of disc disease and then the disc bulge as a result of the tear. He agreed that it was a disc bulge and that disc material had not necessarily herniated. The tear caused axial back pain, not radicular pain, and the axial pain is due to the tear impacting sensory nerves on the disc surface. (Px8; Px9).

Dr. Salehi testified he generally will bring up possible surgery after 6 months of conservative care (therapy, injection(s), and time) without a satisfactory resolution. If the patient at that point declines surgery, there would be an MMI determination and recommendation for functional capacity evaluation (FCE). Petitioner's complaints were ongoing back pain at rest from two to three, going up to seven out of ten with activity, and Dr. Salehi's impression was Petitioner's improvement with conservative care was not significant. In January 2018, he complained that his condition was worsening, so Dr. Salehi recommended surgery. He did testify that Petitioner's complaints of pain radiation to the legs or the leg giving way was referred pain from the back and not radicular. (Px8; Px9).

Dr. Salehi opined that the incident of 3/14/17 was an aggravating event that worsened the Petitioner's preexisting low grade low back pain. He testified that he reviewed the Petitioner's 2012 MRI films as well and that the 2017 films showed a progression and worsening of his L4/5 disc condition. He testified that a fall on the stairs could easily have aggravated the disc, as it was already in a worsened state, and that Petitioner reported an increase in his symptoms versus prior to 3/14/17. He testified that Dr. Bicek's report of Petitioner complaining of low back pain ranging from 2/10 to 5/10 in February 2017 does not impact his opinions. Asked if the changes shown on MRI was a natural progression or one that could have been caused by trauma, the doctor testified: "Either/or. I mean, I guess it would be impossible to say one way of the other, but both would be a competent cause of that progression." As to Petitioner's complaints of increased pain bending over to pick up a litter box, Dr. Salehi testified that "any forward flexion posture puts more pressure on the disc and loads up the disc, and they would have more symptoms from it." Pending surgery, he testified that Petitioner was unable to do his regular job. (Px8; Px9).

On cross-examination, Dr. Salehi acknowledged he was not told when the Petitioner had been struck by a car and testified that the Petitioner did not inform him that he had previously discussed lumbar surgery with a surgeon. His impression was that only conservative care had been considered at that time. While he agreed this

is information he would want to know, he denied that this impacted his causation opinion. He first learned Petitioner had undergone a prior lumbar MRI when he brought a CD of the 9/26/12 films into his office on 10/17/17, which Petitioner acknowledged in his testimony. Dr. Salehi agreed Petitioner's primary pre-accident diagnosis for his preexisting back pain was degenerative disc disease, and he agreed that this is a condition which slowly progresses over time. He again indicated it is impossible to determine if degeneration seen on MRI is due to this progression or a trauma, so he isn't surprised to see it in the regardless of trauma. (Px8; Px9).

Dr. Salehi testified that Petitioner just told him he had a fall on the stairs and had pain in his elbow and back. He wasn't any more specific than that, including whether he had symptoms immediately or within days afterwards. He did not know how many stairs he fell down, but assumed it was more than one: "It wasn't like he just missed the step. He came down – he came down on the body, and it's like he may have taken the blow with his arm." He testified that back pain from a trauma can take a few days to occur, or Petitioner's elbow injury severity could have masked a back injury. Dr. Salehi corrected his direct testimony, where he agreed he'd held Petitioner off work early on, testifying that he hadn't done so, and that Petitioner continued to work so he could make money. Respondent's counsel pointed out that Petitioner had been working up to the point he saw Dr. Salehi that he wasn't hurting for money at that point, and Salehi testified he was still having symptoms. He initially issued work restrictions on 7/19/17, noting Petitioner had been unable to drive after he started taking Tramadol. Dr. Salehi testified he took Petitioner off the drug at that point, as he "usually don't like patients on narcotics for chronic back pain." He testified he started Petitioner on Celebrex, and as to why he then continued to hold him off driving despite ending the narcotic medication, Dr. Salehi testified that if the company vehicle involves bouncing up and down, that is what he was actually restricting, not general car use. He acknowledged Petitioner indicated he was continuing to take Tramadol on 11/14/17, testifying he wasn't prescribing it and possible Dr. Farag was. He agreed he had not spoken to Dr. Farag about Petitioner nor had reviewed any of Farag's records. He testified that SI joint injections may have been prescribed by Dr. Farag, and when the injection failed it indicated "they were barking at the wrong tree." (Px8; Px9).

Dr. Salehi was not aware Petitioner had multiple February and March 2017 workers' compensation claims until he was informed of it by Petitioner's attorney on the day of his deposition, and he was not aware of any pre-3/14/17 medical records. Dr. Salehi agreed that other events, such as lifting a cat litter box, could "aggravate" Petitioner's back condition, but that when it comes to the accident itself, what he means by "aggravation" is Dr. Salehi explained that his definition for aggravation for a preexisting condition is "something that materially changes the spine so the pain keeps going, you know, at the high level." The more minor events are something that increases pain at that moment but is temporary. He did not see any Waddell signed regarding Petitioner. Dr. Salehi acknowledged that the issue of causation can be complicated when there are multiple reported accidents. (Px8; Px9).

10/15/18 pre-op testing with Dr. Bicek indicated no contraindications to surgery. (Px9B). Petitioner testified he was continuing to take medication and use a lidocaine cream but that they did not really help. He was continuing to have pain up to 6/10 to 7/10 with exertion and a return to 3/10 at rest. He reported no real social life due to pain and lack of funds. Petitioner testified the planned 10/31/19 surgery was being authorized via his group health carrier.

Subsequent to his 10/19/18 testimony, surgery was performed by Dr. Salehi on 10/31/18 involving decompression and fusion at L4/5, and including facetotomy, discectomy and arthrodesis of the endplates. Post-operative diagnosis was an L4/5 annular tear resulting in mechanical back pain and degenerative disc disease. (Px9B; Px17).

Petitioner testified he was continuing to follow up with Dr. Salehi through the time of his 10/11/19 testimony. On 11/13/18, he indicated to Dr. Salehi that he was taking up to 10 to 12 Norco per day with low back pain. Dr. Salehi advised him to limit this to 6 and increased his Robaxin frequency and ordered physical therapy to begin. Petitioner was continued off work, noting at the next visit he was to be released to light duty, which was to last for 6 months post-operatively. (Px9B; Px13B). Therapy at ATI was reinstituted starting on 11/21/18. (Px13B; Px15)

On 12/27/18, Petitioner reported he was doing very well with little if any pain. He was not taking any medication but "does admit to having smoked a couple of cigarettes recently." He was to continue therapy for 6 more weeks and was released to light duty (no lifting over 20 pounds, no push/pulling over 35 pounds, no bending/twisting more than 3x per hour, and alternate sit/standing every 30-45 minutes as needed). (Px13C).

Interestingly, a Modified Oswestry Survey completed at ATI indicates Petitioner reported his pain was bad and he could only lift very light weights, though he didn't need to take medication. His pain prevented him from sitting more than a half hour or standing more than an hour. (Px15A). ATI indicates the Petitioner was discharged from therapy by Dr. Salehi as of 2/4/19., though it is unclear why as he was showing improvement and had not yet reached all of his planned goals. Therapist Nicole Milnamow's note states: "The patient did not meet the remainder of the long-term goals because: The patient has reached maximum medical benefit from therapy and has been discharged from therapy." (Px13C; Px15).

On 2/6/19, Petitioner reported he was doing very well with no pain at all, just tightness and muscle pain into the bilateral hips. He denied leg pain or paresthesias. He was to continue home exercise and light duty restrictions. On 3/21/19, Petitioner was doing well, noting some sharp low back pain when he wakes up that resolves once he stretches. He denied leg pain or numbness and he remained non-smoking. He was performing home exercise and trying to stay active. Home exercise and light duty restrictions were continued pending healed fusion, after which work conditioning was planned. (Px13C)

Documentation dated 7/29/19 indicates that the Petitioner was applying for Social Security Disability. However, it appears that documentation completed by Dr. Salehi on 8/14/19 indicated very little expected limitations on Petitioner's abilities. (Px13C).

Petitioner acknowledged a prior work injury to his low back when he was struck by a car in August 2012. A 2015 Hearing was held on the issue of a herniated disc versus an annular tear versus a strain. He received TTD, but treatment was in question. Petitioner returned to unrestricted work duties on 11/25/12. He was still in pain, but Dr. Mollsen told him the pain wouldn't go away overnight and said to wait a year and see how he did. He treated at DuPage. He went back after a year, late 2013.

Petitioner testified that he is required to return to work within two years of being off work in order to remain in his position.

On cross-examination, Petitioner testified supervisor Ryan closed the door almost immediately after he reported the slip and fall on the stairs, and that he was taking photos of the stair areas outside the office, at the landing and on the ground floor. Petitioner testified he didn't tell Ryan where on the stairs he fell before Ryan went to take photos. He agreed he only told Ryan he hurt the left elbow on 3/14/17 and didn't complete any paperwork that day 3/14, testifying he is left-handed and wasn't able to use the left arm to write. However, when he was shown Rx6, he agreed the documentation was in his handwriting and signature but did not recall writing anything on 3/14/17. Petitioner says he wasn't provided with this documentation in a FOIA request sent to Respondent. While Don Ryan testified he took photos using a cell phone, Petitioner reiterated that Ryan was using a camera when he took the photos.

As to his back condition, the Petitioner testified that at the doctor's office on 3/14/17 his elbow was in severe pain. He acknowledged he still was having some back pain from the prior incidents but couldn't say if his back pain was worse that day. When his elbow pain subsided, he noticed his back hurting.

Petitioner testified that Slack and Berardi were about 10 to 12' away when he fell, and he assumed they would have seen or heard him fall. He may have said something to them as they did turn and acknowledge him, but he testified he was embarrassed and got up pretty quickly, so they didn't come help him. He may have asked if they saw what happened. He fell forward and his entire body was on the stairs, testifying he came down on his side across 4 or 5 stairs. He may have sat down on the steps before he arose. After he fell and he looked back, there was water on the floor. He listed Berardi and Slack as witnesses because they were present. He testified that one of them may have asked if he was alright. He didn't say anything to them about his left elbow.

Petitioner indicated he didn't have further treatment following the 2/5/17 incident because he was told he had bursitis and was advised to return to work, and the Respondent wasn't approving physical therapy. He did not recall whether he had been informed that it wasn't being approved on 3/14/17 before going into the garage. He was wearing the seatbelt on the street sweeper but testified the seat itself goes up and down along with the seatbelt. He estimated he rose 8 to 12 inches up to hit his head on the roof.

Regarding his 2012 back injury, Petitioner acknowledged that surgery was denied in 2014 or 2015. He testified he changed his diet and started working out at that point and got back in great shape prior to these work incidents. He did tell Salehi he had a prior back injury years before, but otherwise indicated he had typical aches and pains that everyone has from various activities, but nothing that would prevent him from his routine. He testified he wasn't sure if he told Dr. Salehi that Dr. Deutsch had recommended disc replacement surgery. He did tell Dr. Salehi he had severe back pain in 2012, and he probably said he had surgery prescribed at that time. He agreed he didn't return to Dr. Deutsch again after his request for surgery was denied after a hearing.

Petitioner agreed on further cross that he had been mugged and car jacked on 4/19/17, where he was thrown to the ground, got kicked in the head a few times and had his wallet and car stolen. He believed it was the same day he had his MRI. He reiterated that he continued working without restrictions both before and after 3/14/17 until August 2017. He testified he may have told co-workers he was having problems while continuing to work between March and August 2017, but he agreed he never told Don Ryan about back problems between 3/17 and 8/17. Asked for more detail about the alleged accident on cross, Petitioner testified he didn't think his left boot made it onto the step, it was on the edge. The stairs are concrete, not marble like the floor.

Petitioner testified he last communicated with Lorenz Slack in October 2017 when he asked if he had given a witness statement because he had tried to obtain Slack's and Berardi's statements via a FOIA request. He testified that Berardi called him the night before his testimony asking where he had to go. That was the only discussion they had. He testified that he did text Slack a few weeks before the hearing to let him know his attorney was likely going to subpoena him to testify and he never got a response.

Petitioner agreed he used a phone to videotape himself sliding across the floor at his workplace in Spring of 2018, indicating the floor was in the same condition it had been in at the time of the accident, as he told Don Ryan his claim was being denied and he wanted to show the area was slippery even when it was not wet. He did the area by the stairs and the upstairs floor. He no longer has that video because his phone it was on was taken when he was mugged. He did show it to his dad.

As to the handwritten note signed by Petitioner, which stated 3/14/17, he testified he was asked to complete it by his boss to document what occurred. As to his indication of slipping at the bottom of the stairs, he testified

he believed he got up facing the bottom of the steps and saw the boot prints at the bottom of the stairs, and this is what he was referencing. On redirect, Petitioner wasn't certain when he wrote the handwritten note dated 3/14/17. He came in to complete the incident forms and medical release on 3/15/17, and Don Ryan actually wrote it out for him. When he returned to work the following Monday, he may have given his statement. He indicated 3/14/17 as the date of the injury, not an indication of when he wrote it.

He testified he continued to perform the weightlifting and cardio routine he had been doing from early 2016 after he fell on the stairs, as it helped his symptoms, though he said he eased up on the weights after the initial 2017 back injury. His back got worse after the fall on the stairs and he stopped doing exercises that would harm his back.

On rebuttal following Mr. Ryan's testimony, Petitioner again denied that supervisor Ryan gave him paperwork to complete on 3/14/17, reiterating that he closed the door on him and then walked by him when he came back out to take photos, and other than Ryan advising him to contact Corvel when they returned to the office, they had no other conversation. He testified that Ryan ultimately asked him the questions and filled out the accident report for him, around 6:30 a.m. on 3/15/17, because he couldn't do it himself do to his left elbow injury, and that the form (Px6) indicates he reported injuring both his elbow and his low back to Don Ryan while they were completing Px6, not just the elbow. The Petitioner reiterated that his boots were wet when he came in the building on 3/14/17 to refill the truck with salt and fuel, and that there had been other times that day where he had to get out of the truck and got wet.

Petitioner also testified that he was very familiar with the street sweeper machine, as he would drive it approximately twice a month for 10 years, and that the seat in that machine had a slow air leak. There was a button he would have to use to add air every 10 to 15 minutes, but on that day it had been deflating, and the pothole he hit was big enough that it caused him to go up and strike his head on the roof before coming back down onto a seat with no air in it. He testified that the machine had a lot of problems and was out of service a lot.

Cross-examined, the Petitioner testified he prepared the documentation in Rx6 a number of days after 3/14/17 at the request of the Respondent, and he put the 3/14/17 date on it because that was the day he was injured, and he gave this documentation to either Mr. Ryan or Mr. Cassman within a week of the alleged accident. He indicated that after Ryan slammed the door in his face, he didn't ask him why he was taking photos at the wrong locations because he didn't want to agitate him any further. He testified he knows he said some profanities when he fell on the stairs and had a severely injured elbow, but he got up relatively quickly because he was embarrassed about falling. As to the street sweeper, Petitioner testified they go no more than 10 miles per hour while sweeping is occurring, but he was driving at highway speeds on the way back to dump when he hit the pothole. He had no records of maintenance to the sweeper.

Between the time of his October 2018 testimony and his updated testimony on 11/14/19, the Petitioner testified he'd undergone the 10/31/18 lumbar fusion surgery with Dr. Salehi, and believed he had therapy at ATI from the third week of November 2018, with progressing activities, until his 2/4/19 discharge. He testified that on 3/21/19, Dr. Salehi felt healing of the fusion was not yet complete. While Dr. Salehi recommended work conditioning along with a home exercise program when physical therapy ended, Petitioner testified he did not attend work conditioning because no one was paying his bills and he didn't feel he was ready for it at that time. As his bills were not being paid, he told Dr. Salehi he wanted to do his regimen at his own gym, as he already knew all the exercises he had been doing, and that Dr. Salehi told him this was okay. Petitioner testified that he mainly did a lot of stretching and mainly leg presses, resistance band training, rowing machine type motions and wall squats, including with a medicine ball.

Petitioner testified he was released from Dr. Salehi's care on 7/23/19, and that he asked him to release him as of 8/12/19, which he did, and Petitioner returned to his unrestricted job duties on 8/12/19. He testified that since he returned to work, he has been a little more cautious than before and that he now does ask for help if needed, mainly with heavier lifting. Petitioner testified he did not receive TTD while off work but did receive disability benefits through his retirement benefit program, indicating this could be replenished "one way or another." He has no pending appointments but planned to see Dr. Salehi for a 6-month follow up in February or March 2020. He continues to work out at his gym prior to going to work at 7 a.m., and this includes walking, stretching and light lifting.

The Arbitrator reviewed the surveillance video presented by Respondent covering three dates: 9/26/17, 2/14/18 and 2/17/18. All begin at what appears to be Petitioner's apartment complex parking lot. On 9/26/17, the Petitioner was seen at approximately 10:12 a.m. walking to his car. He gets inside and can be seen twisting to his right twice to reach into the back seat to perform some activity while seated in the driver's seat. It is difficult to see what exactly is happening inside the car. The Petitioner is then seen bending from outside of the car to reach to the floorboards of the driver's, passenger's and rear seats to pick up trash. He then drives to buy cigarettes at approximately 10:16 a.m. The next activity depicted is Petitioner arriving at Dr. Farag's office at approximately 10:50 a.m. After leaving at 11:23 a.m., Petitioner is seen driving to O'Reilly Auto Parts and then to a Menards or Home Depot. However, he is not shown doing anything beyond walking into the auto parts store. He returns to the apartment at 12:14 and no further video is depicted. The total amount of time filmed was 12:34. (Rx5).

Petitioner is seen briefly walking to his car and moving it within the lot at 11:06 a.m. on 2/14/18. He is seen on 2/17/18 very briefly returning to the apartment complex and backing into a spot. Each of these videos were just over 4:30 long and they show no activity of Petitioner. (Rx5).

Petitioner's prior workers' compensation claim against the Respondent regarding the 8/1/12 incident where he indicated he was struck by a car was identified as case number 12 WC 29972, and the Respondent submitted the arbitrator's decision in that matter as Rx3. The Arbitrator notes that the factual findings included in that case indicate the Petitioner sought treatment for his low back and left knee and had a disc replacement surgery recommended by orthopedic surgeon Dr. Deutsch. Arbitrator Kane in that case noted the dispute was based on the Petitioner undergoing three months of care for the low back, after which he returned to full duty work on or about 10/30/12. Over a year later he was noted to have returned to doctors with low back complaints. Petitioner saw Dr. Deutsch on 8/27/14. Arbitrator Kane noted that Dr. Deutsch was the only physician who described Petitioner's condition as involving a disc herniation. He disagreed with the diagnosis of a lumbar strain at the time of the 8/1/12 incident based on Petitioner's stated history that conservative treatment had not been effective and that "the symptoms never resolved other than for short periods of time." (Rx3).

Arbitrator Kane determined that the history indicated in the Petitioner's treatment records following the accident were inconsistent with what he told Dr. Deutsch, i.e. that conservative treatment had not improved his condition and he had ongoing pain after October 2012. The arbitrator found it not credible, along with the idea that Petitioner had continued to perform his heavy work duties routinely while having ongoing significant pain ("It is described as a heavy duty job and it would not be possible for the petitioner to work in such a position for more than a year with complaints and not see a doctor, especially since he was already seeing a doctor for a knee injury and attending physical therapy for approximately two months in 2013. Most critically, the petitioner freely testified that there was an unspecified time when his symptoms began again."). The arbitrator noted that Petitioner's indication that he began to experience pain in his back again at some point contradicted his claim that his back problems had never resolved after August 2012. (Rx3).

Petitioner testified that he still has unpaid medical expenses which he alleges are related to one of the accidents involved in the consolidated claims. His alleged expenses are contained in Px18 through Px25 and Px27.

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:

Th Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of the Petitioner's employment on 3/14/17. The Arbitrator further finds that the Petitioner's left elbow condition is causally related to the 3/14/17 accident. The Arbitrator further finds that the Petitioner's low back condition is not causally related to the 3/14/17 accident.

The Petitioner testified that he slipped on the bottom of the stairs at the Respondent's office building while he was on his way up to the locker room to use the restroom during a break from snowplowing. While his testimony indicates that there was some "tripping" on the stair which contributed the fall, his testimony also indicates that there was some "slipping" due to water on the floor. While a lot of time was spent during hearings regarding how far away the Petitioner parked from the office building, this does not seem particularly relevant to the Arbitrator. The Petitioner's testimony that his boots and lower pants were wet as the result of activities outside of the snowplow during a snow event seems very realistic and likely to the Arbitrator. It is consistent with the testimony of Nick Berardi. Additionally, other workers likely were going in and out of this area, as evidenced by Berardi and Lorenz Slack being present there at the time of the incident. Mr. Berardi and Petitioner's supervisor Mr. Ryan both testified that the terrazzo floor was slippery when wet. Mr. Ryan testified that he summarized what occurred and agreed there are references to water. He acknowledged that there was snow and ice outside that day and there was some water from the door of the garage in the area of the timeclock, though he denied seeing any water in the area at the bottom of the staircase. Even if the Arbitrator were to hypothetically find that the Petitioner only "tripped" on the stair, the fact he was coming in with heavy, wet boots likely contributed to such tripping as well, which would also result in the Arbitrator finding the accident to be compensable.

The Arbitrator further notes that both Berardi and Slack testified that they heard a thud when Petitioner was going up the stairs, turned around and saw him getting himself up from being on the stairs. While the witness reports they completed did not reflect knowledge of a work injury to the Petitioner, their explanation was reasonable under the circumstances, as they believed the Petitioner was joking around on 3/14/17 after they heard the thud. The testimony of Mr. Ryan supports that the Petitioner reported the fall immediately and indicated that the floor was wet. The evidence that Petitioner did not respond when Berardi and Slack asked if he was alright, and Berardi's agreement that he did not see the Petitioner holding his elbow when he was getting up from the stairs, does not, in and of itself, prove that the Petitioner was not injured at that time, particularly since he immediately went up the stairs and reported the incident to Ryan.

Taking the whole of the evidence presented, the Arbitrator finds that the greater weight of the evidence solidly supports that an accident occurred on 3/14/17 which arose out of and in the course of the Petitioner's employment with Respondent, involving a fall on the stairs at the Respondent's office building, and that the job duties and requirements involved an increased risk of such a fall on stairs due to the weight of the wet boots and pants as well as moisture on the boots and/or floor.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's left elbow injury is causally related to the 3/14/17 accident. He testified that he struck his elbow directly when he fell on 3/14/17. He testified he reported a left elbow injury to Don Ryan when he reported the accident, and this was verified by the testimony of Mr. Ryan. Petitioner reported a left elbow problem at Advocate, where he initially sought treatment that same day.

The Arbitrator finds that any left wrist injury or condition the Petitioner may have treated for following the 3/14/17 accident is not causally related to the that accident, as there were no complaints regarding this body part for a month after the accident. Given that there is no chain of events analysis support for causation, the Arbitrator would look to a medical opinion, and there is no medical opinion in this case relating a left wrist condition to the 3/14/17 accident. In fact, Petitioner told Dr. Tu he believed the left wrist was related to the accident, and at no point do the records of Dr. Tu indicate an opinion in this regard.

With regard to Petitioner's lumbar condition, the Arbitrator finds that, at most, the Petitioner sustained a minimal temporary aggravation of longstanding preexisting low back pain and a degenerative condition at L4/5, and that his lumbar condition after 3/15/17 was not causally related to the 3/14/17 accident.

The Arbitrator initially notes that the testimony of Mr. Ryan and the records of Advocate both evidence that the Petitioner did not report an injury to his back on 3/14/17. Petitioner's own testimony acknowledged he did not report a back injury to Ryan. While Petitioner testified that he reported elbow and back pain at Advocate, nothing whatsoever is noted about the Petitioner's in the Advocate records. The Petitioner did report a back injury the following day. While it is not unreasonable for an injury to not be felt until the day following a trauma, the context in this case is important given the Petitioner's longstanding history and the fact he complained of a back injury in February 2017, just the month before the incident involved in the case at bar.

The Arbitrator notes that the Petitioner originally injured his low back at work in 2012 when he indicated he was struck by a moving car which then came back and ran over his foot. As noted above, that matter went to hearing and the prior arbitrator indicated Petitioner sought treatment for his low back and left knee and ultimately had a lumbar disc replacement surgery at L4/5 recommended by surgeon Dr. Deutsch in August 2014. Arbitrator Kane in that case noted the dispute was based on the Petitioner undergoing three months of care for the low back, after which he returned to full duty work on or about 10/30/12, then over a year later returned with ongoing low back complaints. This information was not shared by the Petitioner with the doctors who treated him following the 3/14/17 accident.

On 2/14/17, Petitioner saw Dr. Bicek. Petitioner testified that he was prescribed physical therapy, which wasn't approved, but this is not reflected in the records of the doctor that the Arbitrator was able to find. The Petitioner testified that at the doctor's office on 3/14/17 his elbow was in severe pain, distracting him from the back, but he also acknowledged he still was having some back pain from the prior incidents and couldn't say if his back pain was worse that day.

The evidence reflects several instances where the Petitioner has requested specific things at his medical visits, most significantly releases to full work duties regardless of what the provider may have been planning to recommend. Petitioner continued to work full duty and continued to request full duty releases after 3/14/17, just as he had prior to 3/14/17 according to his prior medical records and continued working full duty through August 2017. As indicated by Dr. Wojcik on 8/18/17, the Petitioner indicated he was only there for a note indicating he was limited to certain work duties, as he had been using vacation and sick time and he had no more vacation time left to use until 9/21/17. While it is clear that some of these requests were made by the

Petitioner to work around his employer's employment/lost time policies, it's also the case that he had been working regular duty for months prior to this. Some of this likely involved the fact that he wasn't being covered under workers' compensation for his back, but the avenue to resolve that at the time would have been the 19(b)/8(a) process in 2017, which the Petitioner has availed himself of here.

On 6/20/17, Petitioner reported his low back pain was mild, but he lifted something heavy at work on 6/11/17, aggravated the pain to where it was hard to move and took a couple sick days until he returned to a baseline level. This seems to the Arbitrator to be another example of the multiple back "tweaks" the Petitioner has sustained over the years since 2012.

On 7/13/17, Petitioner told Dr. Farag that his elbow problem had mostly resolved, but that he had mostly left-sided back pain that would occasionally be right-sided, and that the pain made work difficult and that he wasn't playing as much golf as he used to. Obviously, this statement certainly appears to indicate he was continuing to play golf, just not as often. In the Arbitrator's view, this is additional evidence of a longstanding back problem that the Petitioner has continued to work through for many years with flare ups.

While a degenerative condition can be determined to have been aggravated by a work accident, and thus be compensable under the Act in Illinois, the fact is the surgery that has been recommended is elective, just as it was in 2014 when he saw Dr. Deutsch, and Petitioner elected not to have it in 2014 despite ongoing back problems he indicated went back to 2012. Arguably he has continued to perform a heavy job since 2014 and "aggravated" his back multiple times, but as indicated by Dr. Salehi, such aggravations are just temporary exacerbations and don't "aggravate" the back, by his definition of there being some sort of structural change to the condition resulting in permanent worsening. Again, the Petitioner certainly has an argument that he sustained a permanent aggravation of his lumbar spine on 3/14/17, but the picture painted by the credible facts in this case appear to this Arbitrator to show a longstanding back problem for which a single level surgery involving discectomy was recommended going back to 2014, and the only difference between that recommendation and Dr. Salehi's 2017 recommendation was the choice of disc replacement versus fusion for the same problem at L4/5. There was no discrete moment on 3/14/17 where something significant changed for the Petitioner. Instead, he had what appears to have been a fairly significant elbow injury and some complaints of back pain the next day. The levels of back pain he reported were of no significant difference to what he reported to Dr. Bicek in February 2014, and the Petitioner continued working full duty for almost 6 months after 3/14/17. While an aggravation of a condition may arguably worsen the condition in some fashion, the evidence does not support that the 3/14/17 incident changed the course of his care in any way. Instead, it appears the Petitioner was trying to voluntarily delay the inevitable going back to 2012. While there is nothing unreasonable about this, the Arbitrator believes it supports the fact that a virtually identical surgical recommendation had existed going back to 2014.

The Arbitrator also notes some concerning inconsistencies regarding Dr. Salehi. On 8/21/17, Dr. Salehi stated that the Petitioner was not working because his restrictions were not being accommodated and that he "continued" to recommend L4/5 fusion surgery. However, the Arbitrator notes that no records were submitted prior to this visit which reflect either light duty restrictions or a specific surgical recommendation. Dr. Salehi's testimony regarding the SI joint injection was somewhat inconsistent, as he said he believed Dr. Farag had recommended the injection and was "barking at the wrong tree", while his records reflect that he was the one who determined the SI joint might be a pain generator and recommended the injection for both therapeutic and diagnostic purposes. There also was confusion regarding whether he knew the Petitioner was being prescribed a narcotic, and the Arbitrator believes he at least should have known this since he is the one who referred Petitioner to Dr. Farag. On 9/19/17, Petitioner was given light duty restrictions by Dr. Salehi, including no driving a company vehicle, but it had already been planned at that time that he would follow up in 4 weeks and be released to full duty, which would get the Petitioner past the vacation date he referenced in his testimony and

visit with Dr. Wojcik. Again, this shows the main concern of the Petitioner was timing things to suit his employment needs in his view, and that Dr. Salehi was making recommendations based on what the Petitioner wanted, not necessarily what was indicated medically. While there is nothing wrong with this in and of itself, it does impact this case given there is a question of causal connection to a preexisting condition or a work-related condition, and work status often comes into play in these situations.

This determination was not an easy one for the Arbitrator as the Petitioner did report a low back injury by 3/15/17, but the bottom line for the Arbitrator is that the greater weight of the evidence does not support the finding that something occurred on 3/14/17 which changed the Petitioner's lumbar condition in any significant way, and does not support a finding that the recommended L4/5 surgery is causally related to the 3/14/17 accident. The Arbitrator further finds that the treatment after 3/14/17 which relates to the lumbar spine is not causally related to the 3/14/17 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims outstanding medical expenses totaling $27,320.52 (Arbx1). His alleged expenses are contained in Px18 through Px25 and Px27. However, this also is claimed in all three of the consolidated matters, so it is unclear what portion of this amount is alleged to be related to the 2/27/17 accident involved in this case. As it is difficult to decipher these bills, the Arbitrator finds that of the submitted claimed medical expenses, the expenses relating to the left elbow between 3/14/17 and 4/13/17 are awarded. While the 4/13/17 visit mainly involved complaints of left wrist pain, which has not been causally related to the 3/14/17 accident, it is fair to say that this was also a follow up visit regarding the elbow following the aspiration in March, and reasonably related to the elbow injury. The bills relating to the lumbar spine after 3/14/17 are denied, based on the Arbitrator's causation findings (above).

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

Based on the Arbitrator's findings above with regard to the Petitioner's failure to prove his ongoing lumbar condition is causally related to the 3/14/17 accident, Petitioner's request for prospective low back treatment is denied.

With regard to the left elbow condition that the Arbitrator has determined is causally related to the 3/14/17 accident, the Arbitrator notes that there are no pending treatment recommendations indicated within the evidentiary record. Additionally, the Arbitrator notes that the Petitioner testified that his elbow improved significantly following aspiration and use of an elbow pad, and that he has no ongoing significant problems. He hasn't treated for this condition since 4/13/17 when he followed up with Dr. Tu. However, at that time he first complained of recent development of left wrist pain, not the elbow. While the Petitioner told Dr. Tu he believed the left wrist condition was related to the 3/14/17 fall, at no point did Dr. Tu indicate a left wrist condition was causally related to the accident. Based on this evidence, the Arbitrator denies any request for prospective medical treatment relative to the left elbow.

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:

According to Arbx1a, the Petitioner claims entitlement to TTD from 8/18/17 through 9/27/18. This period is related to the Petitioner's low back treatment, not his left elbow. Given the Arbitrator's findings above with regard to causation, the claim for prospective medical is denied.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that while Penalties and Attorney Fees were indicated as a possible issue in the Request for Hearing form, Petitioner's counsel indicated that this was an undetermined issue and that it would be determined post-hearing whether a Petition for Penalties and Fees would be filed. The Arbitrator has not received such Petition, and as a result the Arbitrator finds that this issue has been waived. The Arbitrator would also note that Sections 19(k) and 19(l) do not otherwise appear to be applicable in this case based on the greater weight of the evidence submitted.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC035924
Case Name	PHILLIPS, LONNIE v. ILLINOIS STATE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0180
Number of Pages of Decision	27
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Steven Scarlati
Respondent Attorney	Robert Delaney

DATE FILED: 4/21/2021

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

LONNIE PHILLIPS,

Petitioner,

vs. NO: 17 WC 35924

ILLINOIS STATE TOLL
HIGHWAY AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 30, 2020 is hereby affirmed and adopted.

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

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

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: **4/21/2021**
o: 4/15/21
BNF/kcb
045

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Christopher A. Harris*
Christopher A. Harris

/s/*Marc Parker*
Marc Parker

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

PHILLIPS, LONNIE
Employee/Petitioner

Case# **17WC035924**

17WC008104
17WC008105

ILLINOIS STATE TOLL HWY AUTHORITY
Employer/Respondent

On 4/30/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0312 BOUDREAU NISIVACO LLC
ALAN BOUDREAU
120 N LASALLE ST SUITE 1250
CHICAGO, IL 60602

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

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

1024 IL STATE TOLL HIGHWAY AUTHY
2700 OGDEN AVENUE
WORKERS COMPENSATION DEPT
DOWNERS GROVE, IL 60515

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

APR 30 2020

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
19(b)/8(a)

LONNIE PHILLIPS
Employee/Petitioner
v.
ILLINOIS STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

Case # **17** WC **35924**

Consolidated cases: **17 WC 08104 & 17 WC 08105**

An *Application for Adjustment 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 **October 19, 2018, October 11, 2019 and November 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. ☒ 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 ______

Phillips v. Illinois State Toll Hwy Auth., 17 WC 35924

FINDINGS

On the date of accident, **February 5, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**Unknown**; the average weekly wage was $**1,270.80**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **0** dependent children.

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

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

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 his employment on February 5, 2017

The Arbitrator finds that the Petitioner's low back condition on February 5, 2017 was causally related to the February 5, 2017 accident, but that the accident resulted in a temporary aggravation of a longstanding preexisting lumbar condition.

Petitioner's claims for temporary total disability, incurred medical expenses and prospective medical benefits are denied.

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

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

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

Phillips v. Illinois State Toll Hwy Auth., 17 WC 35924

Signature of Arbitrator

April 20, 2020
Date

APR 3 0 2020

STATEMENT OF FACTS

Petitioner testified he has been employed by Respondent as an Equipment Operator Laborer (EOL). Respondent's main office is in Downers Grove, but they have garages scattered throughout the system, and Petitioner's was located at I-294 and Cermak Road, Maintenance Garage 2, in 2017. An 11-year employee, Petitioner testified he is left hand dominant, and that he has lived in Lisle, Illinois since 2016. The job involves a variety of road-related activities, including concrete / pavement demolition and repair, guardrail repair, cleaning up after vehicle accidents, plowing snow, fixing drainage appurtenances, cutting grass, driving tractors, graffiti removal, cutting trees and brush and driving a street sweeper. Physically, Petitioner testified he would lift from things ranging from a two-pound hammer to a 90-pound bag of cement mix. He indicated there are things that are heavier that he has not personally weighed, such as a 25' piece of guard rail, a tow behind water pump, snowplow blades, spreader boxes for salt, etc. He testified he also has to shovel asphalt and concrete sand.

Petitioner testified he worked 40 hours per week dayshift from 7 a.m. to 3 p.m., Saturday through Wednesdays with Thursday and Fridays off, in early 2017. He would also get overtime, particularly with snow plowing or accident clean up. He would generally work the roads between O'Hare Airport and I-55, which he indicated has lots of interchanges and accidents. Overtime is mandatory in winter, and he estimated he would average 200 hours of overtime during the winter. He would drive a variety of vehicles, anything from pickup trucks to dump/plow trucks, sometimes with large plows. Petitioner testified that his duties would change day to day. He would go to the maintenance garage in the morning to attend a daily meeting and to get his assignment for the day. He and his co-workers would generally work in teams. Petitioner testified his main job was setting up lane closures, along with performing repairs. Petitioner testified that the truck is cramped to drive and can be very bouncy with snow plowing, especially if you do not know the road areas where the plow might catch. In order to cut trees or bushes he would use chain saws, hedge trimmers, lawnmowers and weed whippers. Normally he takes breaks during his shifts, but he noted it is hard to take breaks during snow plowing.

Petitioner testified that weekend assignments are given on Fridays, as there are no weekend meetings, and he had been assigned to work on 2/5/17, a weekend date (and the subject of case 17 WC 35924), cutting trees and brush from sound/noise walls along I-294. He testified he was working with co-workers Erv Quinones and Greg Arredia and he was operating an 18" chain saw. He testified that he did this work for .5 to 1 mile near the Ogden and Hinsdale Oasis Northbound wall from approximately 8 a.m. to 10 a.m. He testified he became uncomfortable from carrying the 20-pound saw while hunched over and had severe pain in his back bilaterally at the belt line when he tried to stand up straight. He let his co-workers know he was going to the truck to rest, and when they came to the truck, he indicated he was having pain and was walking like another co-worker who walks hunched over. Petitioner testified he has had prior low back pain but had no such pain when he reported to work that day. When he didn't improve during lunch break, he called his boss, Phil Cassman, and told him what happened. Petitioner testified that Cassman advised him to contact Corvel to make a report and to take it easy and to wash trucks that day. Petitioner testified that he did not seek treatment. He testified he didn't complete an accident report for Respondent until the following Monday (Px2), because supervisors aren't in the office/garage on weekends and he "didn't think it was too serious." Petitioner spoke to either Cassman or Don

Ryan, the other supervisor at the garage, on 2/6/17. When he spoke to Corvel, Petitioner didn't indicate he needed treatment, and the Corvel nurse advised him to use ibuprofen and ice for a couple days and to call back to obtain treatment if he didn't improve. He continued to work through the following Wednesday but didn't improve so he again contacted Corvel that Thursday. Treatment wasn't approved at Petitioner's choice of the Back Institute, and he testified he was only approved to see Dr. Bicek.

Petitioner saw Dr. Bicek on 2/14/17 and reported the following history: "States he was using a chainsaw cutting trees along the tollway at work on 5 February for about hour to 2. He then started having low back pain. He was told to take it easy and wash the trucks the rest of the day. He continued to go to work. Wednesday 3 days later he had more lower back pain. This has persisted. It's worse when he wakes up maybe 5/10. It gets better 2-3/10 during the day." He denied leg pain, numbness or weakness. Petitioner indicated he did not want to be on light duty at work. Acute low back pain without sciatica was diagnosed and he was prescribed Naproxen and advised to rest. The Arbitrator did not note any statements regarding Petitioner's work status. (Px9A). Petitioner testified that Dr. Bicek prescribed physical therapy and home exercises, that therapy wasn't approved and that he didn't return to see Dr. Bicek. He continued to work full duty, acknowledging he requested a release to return to full duty.

On 2/27/17 (the subject of case number 17 WC 08104), Petitioner testified he was assigned to operate a street sweeper. While driving back to the garage to dump his full load, at highway speed, he hit a pothole or defect in the road, lifting him off the seat and striking his head on the roof. He testified he felt back pain at that time and reported the incident to either Cassman or Ryan. He again was advised to contact Corvel, which he did, and was referred to the company clinic.

At Advocate Occupational Health on 2/27/17, Dr. Hyre recorded that Petitioner was driving a street sweeper that day, hit a large pothole and came down hard on a rigid seat, injuring his lower back. There were no neurologic symptoms. Petitioner reported a prior history of herniated discs. Dr. Hyre prescribed a Medrol dosepak and released Petitioner to return to regular work duties "Per pt request", noting Petitioner was "refusing any work restrictions." The discharge states: "Follow up with Illinois Back Institute per your request." (Px10). Petitioner testified he believed he and Dr. Hyre discussed his job duties and what type of work he was going to be returning to, as well as that he had a preexisting back condition going back to 2012. He again acknowledged he didn't want to be off work and asked her to return him to regular duty, which he did the next day, 2/28/17.

Petitioner testified he was feeling "about 90%" at work on 2/28/17. He was assigned that day to use an air hammer to break out collapsed drains on the side of the road, remove the concrete and then pour new concrete. Concrete preparation involves mixing a 90-pound bag of cement mix, 15 shovels of gravel and 15 shovels of sand. He estimated he had to move about 5 tons of broken concrete that day, and that he "also" bumped into the truck a couple of times, injuring his left elbow. He recalled using approximately 10 bags of concrete. Two coworkers were using the shovels. He also was asked to help two other workers to remove broken up concrete, testifying they filled the back of a pick-up truck about 3' above the truck sides. He testified that towards the end of the shift he bumped his left elbow. Believing he hit his funny bone, he shook it off and went back to work. When he later removed his long sleeves, he noticed that his elbow was swollen. He had a pre-planned day off the next day and his regularly scheduled two off days off after that. He called Corvel and was sent back to Advocate Occupational Health.

Petitioner returned to Dr. Hyre on 2/28/17 (4:59 p.m.), this time reporting swelling and moderate pain at the left elbow: "I was doing a lot of heavy construction today, I struck my left elbow several times and I now have pain and swelling of my elbow." There was pain and swelling at the olecranon bursa. There was no abrasion or bruising. Diagnosis was left olecranon bursitis. An x-ray was offered but Petitioner wanted to follow up with his own ortho for this, so he was referred there for further treatment, with Dr. Hyre indicating "urgent ortho

consultation." A left elbow sleeve was provided, and Petitioner again refused work restrictions. (Px10). Petitioner testified that he was sent to Edward Hospital for an x-ray and he requested a full duty release to return to work.

Petitioner went to the Edward Hospital emergency room at 6:47 p.m. on 2/28/17 reporting a left elbow injury: "He was throwing large concrete blocks into the back of a pickup truck for work today when he struck his elbow on the edge of the truck. He noted some increased swelling to the electron area today. Minimal pain." A separate note indicated he hit the elbow on the truck around noon. At this facility. X-rays showed olecranon bursa swelling, slight triceps enthesopathy and no acute fracture or other acute abnormality. Diagnosis was posttraumatic olecranon bursitis. Petitioner was offered an Ace wrap but preferred to use his own splint. He was advised to follow up with his primary provider. (Px11).

Petitioner testified he continued to work regular duty through 3/14/17. On that date (the subject of case number 17 WC 08105), it was snowing and he was assigned to a plow truck driving between Cermak Road and I-90 on I-294. He came back to the garage to load salt and fuel the truck, parking outside of the garage to use the restroom. Petitioner testified it was wet and snowy outside, including in the parking lot, at the salt dome or at the gas pumps. Trucks pulling in and out made the garage area wet as well. He testified he was wearing work boots that day (see Px26) and that they were very wet when he came into the office building through the garage door. He testified he also had a snow suit on that was wet at the bottom of the pants as well. He testified he walked between 50 and 150 feet to the garage area. He testified that as he went to go upstairs to the second-floor locker room bathroom he slipped and fell.

A photo (Px2) depicts a view going from the garage into office area. The floor inside the office area is marble. There is an area depicted, the "Time clock area", where there is a bulletin board. Petitioner was planning to go up the depicted stairs to the locker room. Petitioner testified this photo was taken after the alleged accident date but testified that the lighting and dimensions shown in the photo are the same as they were on the accident date. In the room when he entered from the garage were co-workers Nick Berardi and Lorenzo Slack, who were talking near the time clock. Mr. Slack was a relatively new employee at that time, maybe 2 to 3 months. Petitioner walked by them to go up the stairs. He testified he asked if they were clocking out, but he was not sure if they heard him as they didn't acknowledge him. As he went to step on the first stair, he testified he caught it with the toe of his boot, and as he went to go to the second step, the toe of his other boot slipped off the first step and he fell forward onto the stairs, landing on his left elbow and left side. After cursing, he got up and went upstairs. He went to supervisor Don Ryan's office on the second floor and reported he had fallen on the stairs and had severe elbow pain. Petitioner testified that Ryan slammed the door in his face. Confused, he waited for a bit to see if he was coming out or not. After a few minutes Ryan came out, walked past him without saying anything, and took a camera and started taking pictures of the stairs. Petitioner followed him down the stairs. They didn't speak further. Petitioner noted he started taking pictures himself when he didn't think Ryan was taking pictures in the right spot. When they then went back upstairs, Petitioner indicated he had slipped up the stairs, as his boots were wet and there was some water on the stairs. He testified he indicated his boot prints were there. He testified that Ryan then advised him to call Corvel.

Petitioner identified Px3 as a photo he took at approximately 11:57 a.m., which was about five minutes after he first reported the incident to Ryan. He testified that the marks on the floor in the photo are from his boot prints, which showed the path he walked. Petitioner testified he stepped up on the stairs with his left foot, toe on the edge of the step, went to push off to put his right foot on the next step and his left toe slipped off. He testified that he may have asked Berardi and Slack if they saw what happened, but he didn't stop to talk to them. He didn't think they were still present there when he went to take the photos, and he indicated he hadn't told them anything about the injury or what happened.

Philip Cassman testified that he works as a maintenance section supervisor for Respondent, and that he was the Petitioner's immediate supervisor working out of Maintenance facility 2 in Hillside in 2017. Don Ryan was the manager of the maintenance facility. Cassman testified his duties include giving out daily job assignments, following up on them and dealing with safety issues. Mr. Cassman was aware of Petitioner's three pending workers' compensation claims. On 2/27/17, Petitioner came into the office and reported he hurt his back working on the sweeper. He had assigned Petitioner to a road shoulder sweeping job in the number 259 sweeper, and the Petitioner reported hurting his back when he hit a pothole. He gave the Petitioner injury reporting paperwork and advised him to call Corvel. Petitioner had already spoken to Corvel because they had canceled a previously scheduled doctor's appointment that he was supposed to have later that day related to a prior back claim. He then advised Don Ryan that Petitioner reported hurting his back. He then went down to inspect the sweeper, including the seat and tires, and it was operating properly. He testified the machine had an Air Ride seat, which provides a smoother ride. Cassman testified he went with mechanic Jim Murphy to look at the sweeper to make sure the air ride seat was working and that it didn't leak air, and there were no air leaks found. He also testified that in the two years between March 2015 and March 2017, no one had ever complained about problems with the seat in #259. The machine is serviced every 100 hours of use by going through a checklist. He further testified that if the machine breaks down it would be brought in to be fixed, and while he acknowledged that #259 was in the shop quite a bit for mechanical problems, this involved mostly conveyor or broom issues. He doesn't review the repair sheets himself; he is informed of what the problems are by the mechanic. He had no knowledge of physical maintenance records and he could not say how old the machine was in 2017. Mr. Cassman testified didn't spend a lot of time on the machine but has driven #259 himself when he initially was promoted to supervisor in 2015 and it was working fine and did not involve a bumpy ride in his experience. As to the 3/14/17 incident, his understanding is Petitioner was hurt entering the stairway in the building. He verified that Mr. Slack and Mr. Berardi were also EOLs for Respondent, and that there is a time clock in the office building stairwell where employees have to use a badge and fingerprint to punch in and out. On cross-examination, Mr. Cassman testified he had not driven sweeper #259 again after March 2015, at which time it was working fine.

Donald Ryan, Respondent's Section Manager for the Tollway since 2011, testified that he oversees and manages an assigned maintenance facility, currently at the Arlington Heights facility but in 2017 was at the Hillside location, Number 2, and Petitioner was one of his employees there. He gives out the daily assignments to the day shift workers, does other paperwork and goes out on the road to check up on work crews and to look for roadway deficiencies. Mr. Ryan testified that as section supervisor, Mr. Cassman was basically his assistant but that they are more or less equals with the same responsibilities and coordinate with each other on what they are going to do. Mr. Ryan verified his office is on the second floor of a two-level building where the first floor is a hall to the upstairs and the garage where mechanics and trucks are. His office can be accessed from the west side, between a wall and the building, and on the north side by walking through the garage, into the hallway near the time clock and up the stairs.

On 3/14/17, Mr. Ryan acknowledged that there had been a two day show and ice event and the workers were out plowing snow. Sometime around noon the Petitioner came in and advised that he had slipped and tripped up the stairs and hurt his elbow. Someone was present at a table in the common area outside of his office, but Ryan could not recall who it was. He told the Petitioner he thought he had previously hurt the elbow and that Petitioner said he reaggravated it. Mr. Ryan advised Petitioner to contact Corvel. He then got paperwork for Petitioner to complete and testified the Petitioner went to the conference table in the common area while Ryan went to the stairs to take photos of them near the office door, at the landing, and at the bottom of the stairs, which he identified as Rx7. He then went back into his office, closed his door and made the necessary phone calls he needed to make. He testified he took the photos with his cell phone, not a camera, noting the facility got rid of cameras once cell phones were readily available for any needed photos. He estimated he took the photos about 5 to 10 minutes after Petitioner reported the incident. Mr. Ryan could not recall any specifics of where the

Petitioner fell on the stairs and didn't recall the Petitioner ever saying where exactly where he fell, all he recalled is that he tripped up the stairs.

Mr. Ryan testified that he summarized what occurred and agreed there are references to water. He acknowledged that there was snow and ice outside that day and there was some water from the door of the garage in the area of the timeclock, but he did not see any water in the area at the bottom of the staircase. He testified that he didn't see the Petitioner near the stairs when he was talking the photos and didn't see the Petitioner take any of his own photos. Mr. Ryan testified that the floor is terrazzo at the base of the stairs and the stairs themselves are concrete, which are less slippery than the terrazzo floor. He testified that he had not seen Petitioner's photo of the stairs prior to the hearing date, and indicated he did not see the alleged boot marks on the floor at the bottom of the stairs when he was taking photos, just the wear on the floor, and he verified the photos he took accurately depicted the condition of the stairs that day.

Mr. Ryan agreed that Petitioner would have been plowing snow that day and there would have been a number of reasons he might have needed to be outside of the truck that day. Most employees park between the salt dome and building on the north side when they come inside, which he indicated this would be anywhere from 20' to 30' away from the building, while it could be 5' to 10' if you park next to the building. Mr. Ryan testified the Petitioner did not say anything about injuring his back that day and did not initially indicate there were witnesses. After Petitioner went to the company clinic he returned to the office and he and Ryan briefly spoke again, including about Mr. Berardi and Mr. Slack being witnesses, and Petitioner then provided his written statement, listing Berardi and Slack as witnesses. Mr. Ryan did not recall seeing either of them downstairs when he was taking the photos. The next day he testified he approached Berardi and Slack individually to ask what they were aware of, as they were busy on 3/14/17 plowing snow. The Petitioner provided his written statement, listing Berardi and Slack as witnesses. Mr. Ryan testified he regularly deals with workers' compensation claims, and when an injured employee indicates there were witnesses to an incident, he is required to obtain statements from them. He met with Mr. Berardi and Mr. Slack separately in his office between 7:00 and 7:30 a.m., advised them they had been listed as witnesses and that they needed to prepare statements about what they knew. Both of them indicated it was the first time they had heard about Petitioner claiming injury, and each of them completed their own statements (see Rx1 & Rx2). Once he gathers all pertinent information about a workers' compensation claim, Mr. Ryan provides that information to management.

On cross examination, Mr. Ryan testified that Petitioner reported slipping and tripping up the stairs and injuring his elbow, he did not report a back injury. He denied slamming the door in the Petitioner's face and denied being angry. He testified that after he gave the Petitioner the employee injury report packet to complete, Petitioner sat at the conference table in the common area and was completing the documents. He again testified that the Petitioner did not follow him down the stairs when he went to take photos. Mr. Ryan testified that the Petitioner completed an Employee Accident/Incident Report that day, 3/14/17. He testified that he completed the document in Px6 based on what the Petitioner told him. While Petitioner was supposed to complete it and sign it, Mr. Ryan testified he refused.

Mr. Ryan did acknowledge that he checked the box in the documentation indicating injury to the lower back on 3/15/17 but testified that he didn't recall what the Petitioner told him that day. The report states he slipped on some water at the stairs and said he hit his arm while falling or tripping on the stairs. He testified that Petitioner initially said he tripped on the stairs, said there was water in front of the stairs and that he slipped walking up the stairs going to the locker room. Mr. Ryan was not sure if or when he and the Petitioner had a second conversation on 3/15/17. He did witness Petitioner signing the document the next day. As to an indication of striking an object, Mr. Ryan testified that he meant the stairs when he wrote this. Because Petitioner said he slipped on stairs, he took photos of the stairs. Mr. Ryan did not recall what boots or shoes the Petitioner was

wearing. There is water on the floor in that area sometimes, and he testified that building maintenance or janitorial would clean the area, change carpets, etc.

When he was shown the photographs in Px4 & Px5, Nr. Ryan testified that the runner depicted was placed to collect water and dust. The orange cone exists to let people know its slick, noting that the terrazzo is slick when it gets wet. He testified that he would have expected Petitioner's boots to have been wet on 3/14/17. He took the photos in Rx7 between noon and 12:15 p.m. He did say there was water from boot prints in the hallway. While he didn't see the Petitioner do so, he agreed he may have gone down and took photos himself. He agreed the photo in Px3, with an 11:57 a.m. time stamp, depicts marks before the stairs

Mr. Ryan indicated on redirect exam that he may have obtained more information from the Petitioner the day after the alleged accident. He reiterated that the written statement from 3/14/17, Rx6, was completed by Petitioner in his own handwriting, and it indicates he slipped on water and hit his elbow on the stairs with no mention of the low back.

The Arbitrator notes that the photos in Px2, Px4 and Px5 depict the Respondent's office building's lower level. The area is essentially a long room, with swinging glass doors in the front and the gray steel door testified to by the witnesses at the other end. There is a large bulletin board on the wall in the hallway between them, and the board faces the stairwell. As testified to, the floor does appear to be terrazzo and the stairs do appear to be concrete and metal with a solid metal railing. Px3 is a photograph Petitioner identified as one he took on 3/14/17 of the area at the bottom of the stairs. The Arbitrator notes that there are patches of dirty areas at the bottom of the stairs that appear to have been made with shoe wear. The photo is from a cell phone, was taken by someone from a position on the stairs themselves. (Px2 through 5)

Px26 contains side and bottom photos of the Petitioner's boots from the alleged accident date. These photos were purported to show a unique tread on the Petitioner's boots that could somehow be seen in the photos the Petitioner took. However, the only photo that allegedly depicts the marks on 3/14/17 that is in evidence is Px3, and there is no way the Arbitrator can tell whether the marks on the floor were made by any specific boot tread. Petitioner testified that the photograph in Px3 depicts his footprints walking in a semicircle around the railing, and the Arbitrator notes that the location of the marks could be from someone walking from the hallway around the railing and to the stairs.

The Arbitrator does take note that the photos in Px4 and 5, which Petitioner testified were taken by him sometime between September 2017 and May 2018, shows that a carpet runner had been placed in the hallway between the front and gray garage doors, as well as in front of the stairs along with an orange cone. Petitioner testified the cones and the carpet were not present on the alleged accident date and were put in after his injury. The Arbitrator notes that remediation measures that may be taken by a Respondent does not confer liability on them under the Act. However, the Arbitrator does take note of the photos for whatever evidence they may provide with regard to evidence of notice to Respondent.

The Arbitrator also notes that the photo in Px2 appears to have been taken on a day different from both the alleged accident date and the time the photos in Px4 and Px5 were taken, as no carpets were present in the lower level. This photo does depict an "LS" mark that indicates where Mr. Berardi and Mr. Slack were standing at the time of the alleged accident, in front of the bulletin board. The Arbitrator would note that where they were standing appears to be within 5 feet, to 10 feet at the most, from the stairwell, and there would be nothing obstructing their view of the stairs had they been looking at the stairs.

The photographs taken by Don Ryan were also admitted into evidence (Rx7). This includes pictures of the floor and bottom stair, the landing of the stairs, and the floor at the top of the stairs just outside the offices. The

Arbitrator notes that the floor at the bottom of the stairs was quite dirty and appears to be dry, but also acknowledges that this is very difficult to perceive by simply looking at the photos. (Rx7). The Arbitrator would also note that the area photographed by Mr. Ryan is directly at the bottom of the steps and includes the bottom stair, while the Petitioner's photo shows mainly the area just beyond the bottom of the steps towards the glass doors.

The witness statements of Nick Berardi and Lorenz Slack were submitted into evidence. Both statements are dated 3/15/17. Mr. Berardi indicated he did not directly witness Petitioner's accident, and that he was first made aware of the incident "Just now at 7:30 on 3/15/17." (Rx1). Mr. Slack also indicated he did not directly witness an accident, and "Was first made aware when called into the office to ask if I saw it at 7:30 a.m. 3/15/17. (Rx2).

Lorenz Slack testified he began working for Respondent on 1/3/16 as an Equipment Operating Laborer (EOL), with similar duties as Petitioner, but he was still a hands-on trainee. He recalled he was standing in front of the bulletin board near the time clock (see "LS" on Px2) talking to Berardi sometime between 2:40 and 2:45 p.m., as he punched out at 3 p.m. on the dot. They had worked together that day and were talking about something they were looking at on the bulletin board. His back was to the stairs when he peripherally saw the Petitioner walk in through the gray door from the garage. He did not if Petitioner said anything or not. While he was still facing the board, he heard a yell and a kind of foot slap sound. He turned around and saw the Petitioner sitting on the stairs with his elbow on the rail pulling himself up. He testified he was on the first or second stair. He testified he did not see any actual incident and did not see the Petitioner fall. When he heard the sound, he turned around and thought the Petitioner had been joking around. He testified the Petitioner asked, "Did you see that?", Berardi asked him if he was alright, Petitioner didn't respond and he went up the stairs.

The next day, Mr. Slack testified that Ryan and Sweeney pulled him into the office to ask about Petitioner. He testified he initially didn't know what they were talking about, and they told him Petitioner hurt himself and said Slack saw him fall down the stairs. He told them he didn't know what Petitioner was talking about and didn't know he was hurt, as he thought the Petitioner had been joking around and he had no idea anything was going on. Ryan asked him to then just then write that he didn't see anything, which he did (Rx2). Mr. Slack testified that he and the Petitioner are both musicians and have worked together a couple times. They weren't close friends, but they would talk outside of work about music a lot.

Cross-examined by Respondent, Mr. Slack verified that the incident had to have occurred sometime between 2:45 and 3 p.m., as that's the only time he would have been in that area. He testified he was in that area for about 15 minutes after washing trucks outside and changing blades on the plow. He denied that this could have been around noon as he never punches out that early. He did not recall seeing anyone's footprints. At that time, he testified a shift would all be punching out, which he estimated would be 12 to 15 guys. They would go to the locker room upstairs to change then come back and sit down until 3 p.m. He acknowledged receiving a text from Petitioner 2 or 3 weeks before his testimony indicating his attorney would be contacting him, and that he hasn't had any discussion with anyone else since that time. He only discussed what had transpired at work with Petitioner's attorney the day of the hearing.

Slack testified that guys in the garage joke around with each other a lot and he reiterated that when Petitioner didn't respond to Berardi asking if he was okay, he assumed Petitioner was joking around. He believed the Petitioner was using his left arm to pull himself up. He estimated he was approximately two to four feet away from Petitioner when he heard a thud and a yell, and he turned around a second later. He was told the next morning by Ryan and Sweeney that Petitioner said he fell on the stairs, and he told Ryan he didn't initially know what he was talking about because he thought Petitioner was joking, but that he heard Petitioner yell, saw him on the stairs, asked if he was okay and Petitioner walked up the stairs.

Nick Berardi, also an ELO for Respondent, testified that he had been off work since 4/23/18 himself due to his own work injury. He has worked together with Petitioner often and testified they shared the same basic job duties. They would work in teams and would all contribute to jobs, and he indicated the Petitioner performed well on the job. He described the areas upstairs and downstairs in the office building as depicted in Px2. Berardi testified he did not recall what the Petitioner's assigned job was on 3/14/17. He saw him at the morning meeting but did not work with him that day. He verified that it was cold and wet that day and that his boots and pants got wet. Sometime between approximately noon and 12:15 p.m. that day he testified he was talking to Mr. Slack, who he worked with that day, and they were looking at something on and facing the bulletin board. He noticed the Petitioner walk in from the garage, they said hello to each other, and he went back to talking to Slack. He testified he then heard a thud, turned and saw that Petitioner appeared to be in the motion of getting up on the stairs. He asked the Petitioner if he was okay, but the Petitioner didn't answer him or say anything more and continued up the stairs. He testified that the thud sounded like someone fell and hit the pavement, causing him to turn around. He saw the Petitioner getting up from laying on the stairs, recover his stability and then walk up. He testified that the floor is slick when work boots are wet.

Berardi testified he was first made aware that Petitioner had an accident and said he got hurt following the morning meeting on 3/15/17. Foreman Don Ryan asked he and Slack to come into the office to prepare a report, indicating he said they were witnesses to him falling on the stairs. Berardi asked if they meant from the day before and they said yes. He agreed he completed Rx1 in his handwriting on 3/15. He reiterated he heard the thud and saw Petitioner getting up from the stairs but didn't know he had been injured at that time. Mr. Berardi verified that the rugs depicted in Px5 were in the building in March of 2018, and he acknowledged that the floor and stairs can be slippery in the building, noting hard toe shoes are required for the job.

On cross, Berardi testified he was working with agreed that while he normally punches out at 3 p.m., he was in the office building at noon because they must have been taking a break. He acknowledged that he and Petitioner became work friends and they would joke around a lot. The bulletin board was about four feet away from where Petitioner was on the stairs and he turned around immediately when he heard the thud. Petitioner was in a prone position when he turned around, lying on his stomach up the stairs. He verified that he prepared Rx1 after being told Petitioner reported falling on the stairs and that he witnessed it. He indicated he didn't witness an injury because he didn't visibly see him fall since his back was turned. He indicated he was made aware of the accident/incident "just now" because he didn't realize Petitioner had been injured. When he had asked Petitioner if he was okay, he didn't say anything, and after collecting himself for a second or two he continued up the stairs. He did not notice Petitioner holding his elbow, but he was looking to see if he hit his head and didn't focus on anything else.

Petitioner testified he was again sent to Advocate by Corvel, and he again saw Dr. Hyre. An initial injury report at Advocate Occupational on 3/14/17 (12:40 p.m.) notes: "Slipped and fell on stairs hitting elbow hard." The progress note states: "According to the pt, while at work, he was in a stairwell talking to coworkers when he slipped on water, fell, and landed on his left elbow. He reports pain and swelling in the left elbow. He does have a previous injury to that left elbow about a few weeks ago and the swelling has been there since that injury. The swelling never subsided from that injury and now he reinjured the left elbow when he fell today." Left elbow x-ray showed an ossific density at the dorsal aspect of the olecranon process with associated soft tissue swelling, concerning for an avulsion fracture. Correlation with point tenderness was recommended. Diagnosis was left elbow contusion, and an avulsion fracture of the olecranon process. Petitioner was restricted from left arm use and referred for orthopedic evaluation. (Px10; Rx4).

Petitioner testified he reported both elbow and back pain at Advocate. Petitioner acknowledged that he only reported elbow pain to supervisor Ryan on 3/14/17 because he had a lot of elbow pain. He testified that by the time he left the clinic the supervisors had gone for the day so he couldn't complete injury paperwork. Petitioner

testified that after being diagnosed with an avulsion fracture the doctor was going to schedule him with an orthopedic surgeon.

On 3/15/17, Petitioner went to the garage at 6:30 am and dictated an accident report to Supervisor Ryan, indicating that he hurt his elbow and low back. Respondent submitted a one-page document into evidence, dated 3/14/17, alleged to have been signed by Petitioner, which states only the following: "Slipped on water at bottom of stairs. Fell & struck left elbow on stairs." (Rx6). Petitioner testified he also completed an Employee Accident/Incident Report Form (Px6) on 3/15/17 where he also indicated back symptoms.

Petitioner testified the 3/15/17 (Px6) was filled out by Don Ryan and that Petitioner then signed it. The Arbitrator notes this document indicates the Petitioner reported an incident occurring at the garage on 3/14/17 at 11:45 a.m. and that it was reported around noon. The document further indicated that he injured the left elbow and low back due to a fall and striking against an object. These are noted via check marks to injury types that are already noted. The incident is described as "coming upstairs to go to locker room", and that he slipped on some water "at or in front of stairs." Berardi and Slack were indicated as witnesses. It also notes the injury was immediately reported to the supervisor. It is signed by Petitioner on 3/15/17 and Mr. Ryan signed off indicating he witnessed the signature. (Px6).

Petitioner testified that when an orthopedic visit had not yet been scheduled for him, on 3/16/17 he contacted an attorney. On 3/16/17, Petitioner saw Dr. Tu at G&T Orthopedics for left elbow swelling following a work injury. Petitioner was noted to be left-handed. He reported that on 2/28/17 he was doing concrete work when the back of his elbow hit a concrete truck. When he later took off his sweater, he noticed the elbow was swollen. He noted he went to Edward Hospital for x-rays when occupational health did not have an x-ray available. Petitioner reported he then returned to regular duty until 3/14/17, when he tripped on some stairs and struck his left elbow. It was noted he was "diagnosed with an avulsion fracture, also started complaining of back pain. Since his recent injury, he has some swelling in the back of his elbow, does not have really any significant pain. He does have lower back pain." Dr. Tu diagnosed traumatic left olecranon bursitis and lower back pain. Dr. Tu opined that the direct trauma to the posterior elbow was a significant contributing factor to the development of the condition. The bursa was aspirated, and the elbow was compression-wrapped. He was released to full duties and advised to use an elbow pad. He was referred to neurosurgeon Dr. Salehi for the low back. (Px12). After draining his elbow, Petitioner testified that Dr. Tu recommended an elbow pad and felt he didn't need surgery. Petitioner testified on 10/11/19 that his elbow was fine and he was having no problems with it.

Petitioner initially saw Dr. Salehi on 3/23/17. Petitioner reported on 3/14/17 he fell down some stairs at work and since that time had left elbow and low back pain. He denied pain or numbness radiating to the legs. He was working full duty. Petitioner acknowledged that he was hit by a car at work many years prior, had low back pain, three months of therapy and was "then told to return to work. He stated that since that time he had some low-grade back pain but that it was never to the degree that it is currently." Physical therapy and lumbar MRI were prescribed. (Px9B; Px13A).

On 4/13/17, Petitioner returned to Dr. Tu. He reported his elbow symptoms had improved with aspiration but that about a week after his original work injury he started to get left wrist pain: "He feels that it was after a fall at work since his injury, he has difficulty with extension of the wrist." Dr. Tu diagnosed a possible triangular fibrocartilage complex (TFCC) tear and ordered a left wrist MRI. He was allowed to continue regular duty. (Px12).

Lumbar MRI films obtained on 4/19/17 indicated mild loss of intervertebral disc space height and loss of normal T2 hyperintensity of the disc material with a small posterior broad-based disc protrusion. There was minimal associated central stenosis and foraminal narrowing. (Px9B; Px13A; Px14).

On 5/2/17, Petitioner reported 2-3/10 low back pain at rest that could go up to 7/10 with work activities. He denied radiation of pain. Dr. Salehi noted single level degeneration at L4/5 with a small paracentral and right disc bulge. He indicated Petitioner had low back pain secondary to aggravation of L4/5 disc disease/annular tear and recommended physical therapy, noting Petitioner could be a fusion candidate in the future if his symptoms persisted. Mobic was also prescribed. (Px9B; Px13A).

On 5/4/17, Dr. Tu indicated Petitioner reported continued difficulty with full wrist extension and that they were still awaiting MRI authorization. (Px12).

When Petitioner followed up on 5/30/17, he reported no low back improvement with therapy, which is consistent with his testimony. Dr. Salehi continued to advise therapy and allowed Petitioner to continue to work full duty. On 6/20/17, Petitioner reported his low back pain was mild, but he lifted something heavy at work on 6/11/17, aggravated the pain to where it was hard to move and took a couple sick days until he returned to a baseline level. He continued to deny radiation. Noting the pain could be due to L4/5 or possibly also the SI joints, Dr. Salehi prescribed diagnostic and therapeutic SI joint injections along with ongoing therapy and continued him on regular duty. (Px9B; Px13A).

On 7/13/17, Petitioner saw Dr. Farag at Midwest Anesthesia and Pain Specialists based on the SI joint injection recommendation. Petitioner reported his elbow problem had mostly resolved but was still sore from time to time. The back pain was mostly left-sided, occasionally right-sided, with occasional pain down the leg to the knee if the back was palpated firmly by the physical therapist. Petitioner reported the pain made work difficult and that he wasn't playing as much golf as he used to, his favorite pastime. He had been working unrestricted in what Petitioner described as a heavy job and "he prefers to continue working without restrictions." Dr. Farag recommended the SI injections, a back brace, physical therapy, NSAID cream and lidocaine patches. (Px16).

On 7/25/17, Dr. Salehi noted continued left low back complaints with increased intensity based on work activities. He indicated "when the pain is significant it will radiate down the left leg otherwise he denies any radiating leg pain or paresthesias." It would occasionally radiate to the right low back. He was to undergo SI joint injections on 8/3/17 and continue regular duty. On 8/21/17, Petitioner denied pain radiating into the legs. At this point Dr. Salehi stated that the Petitioner was not working because his restrictions were not being accommodated, and that he "continued" to recommend L4/5 fusion surgery. He was advised to stop smoking and to continue on light duty status. (Px9B; Px13A). The Arbitrator notes that no records were submitted prior to this visit which reflect light duty restrictions or a specific surgical recommendation.

On 8/3/17, Dr. Farag repeated his 7/13/17 recommendations. (Px16). On 8/18/17, Petitioner saw family physician Dr. Wojcik, who noted he injured his back when he fell down stairs at work in March and was there for a note indicating he was limited to certain work duties because he had been using vacation and sick time and he had no more vacation time left to use until 9/21/17. He noted he was waiting for Respondent to authorize the SI injection. Tramadol helped but he couldn't take it at work because it made him feel high. (Px9A).

Petitioner testified that Dr. Wojcik restricted his driving and operation of heavy machinery, not physical activities, and that Respondent could not accommodate this. Petitioner testified that when Dr. Wojcik gave him work restrictions from 8/19: "I asked for September 20th because that's my anniversary date, and I would get three more weeks (of) vacation. So I was hoping that if the injections still weren't approved by then, I can at least get back on the clock and ease through my vacation time to get the restrictions, but then I got the injection, part of that. The injection didn't work." He testified he gave an 8/18/17 note reflecting this restriction to Don Ryan on 8/18/17 or 8/19/17, and that Ryan told him he would have to call his boss about it. On 8/19 or 8/20/17, he received a call indicating the Respondent could not accommodate the restrictions and he was then off work.

Petitioner testified he had different counsel when Dr. Farag had prescribed the injection and back brace, which was never approved. The injections weren't performed until August and September. Petitioner denied being told why Respondent would not authorize these prescriptions. He had continued to work regular duty from March through 8/14/17.

On 8/29/17, Dr. Farag performed left SI joint injection. (Px16). It appears that Petitioner attended therapy at ATI from 5/10/17 through 9/13/17, at which point the therapist indicated Petitioner had reached maximum medical improvement (MMI) with regard to therapy as he had plateaued without meeting almost any of the planned short or long term goals. (Px9B; Px13A; Px15).

On 9/19/17, Petitioner told Dr. Salehi the SI joint injection did not help. The report states: "He was given Tramadol for pain about a month ago and since then has been off work as he is not able to drive." Left low back pain with occasional tingling in the left buttock was reported. Given no relief with the injection, Dr. Salehi opined the pain was most likely related to the L4/5 condition. He was changed from Tramadol to Celebrex and given light duty restrictions (no lifting over 20 pounds, no push/pulling over 35 pounds, no bending or twisting), including no driving of a company vehicle. It was noted he would follow up in 4 weeks and be released to full duty. (Px9B; Px13A).

Petitioner testified that Dr. Farag had provided him with Tramadol at his office, and while it helped his back pain, it made him feel kind of "loopy", which he couldn't have while operating commercial machines at work, so he had to take days off while he was waiting for the injection to be approved to avoid driving under the influence. He testified he was told he could no longer take vacation days off for this alleged injury after 8/14/17. Therefore, if he worked regular duty and hurt someone he would have to take a drug test, and he testified he didn't want Respondent to take on that liability. On cross exam, he testified that he continued to drive his car and could not recall if the medication impacted his personal driving. He noted that a CDL license has a higher standard than a regular driver's license.

Petitioner testified that Dr. Salehi indicated his bills weren't being paid by Respondent, and that his prior attorney hadn't informed him that his claim was being denied. He would call his boss every or every other week to report that he still had restrictions. Petitioner testified his understanding of Respondent's policy is that he would need a full release before he could return to work, and this was what Don Ryan told him in August after getting his work restrictions. At some point a Mr. Sweeney became the new section supervisor below Ryan and that is who the Petitioner would talk to weekly or biweekly in August and September to indicate he still had restrictions. Petitioner testified therapy at ATI wasn't helping after 4 months, and neither did the injection, so more aggressive treatments were planned. He had expected he would receive TTD when he went off work on 8/15/17 since Respondent was paying for therapy.

On 9/26/17, Petitioner returned to Dr. Farag and indicated he didn't think the injection helped very much after having 75% improvement the day of the injection. He was taking Tramadol but hadn't tried lidocaine patches. (Px16).

On 10/17/17, Dr. Salehi reviewed a 9/6/12 MRI ("disc disease at L4/5 with mild height loss and small central herniated disc") and compared it to the 4/19/17 films, indicating they showed further loss of T2 signal of the L4/5 disc. Light duty was continued and he was to return following a court date to determine if he would proceed with treatment of obtain a functional capacity evaluation (FCE). On 11/14/17, Dr. Salehi stated that Petitioner "may be a candidate for a lumbar fusion should his pain become unbearable." Light duty restrictions were continued. (Px9B; Px13A). Petitioner testified when fusion was discussed at this point, he was basically sedentary.

On 1/2/18, Petitioner reported continued left low back pain that was worsening with radiation into the legs about once a week. He was not working as light duty was not being accommodated. Dr. Salehi indicated the pain was due to L4/5 disc disease/annular tear, and given the pain was becoming intolerable he recommended an L4/5 decompression and fusion surgery. Petitioner reported he had quit smoking and would need to continue that for at least 9 months post-surgery. Restrictions were continued. Surgery and light duty were again continued on 2/6/18 while awaiting authorization. Restrictions were again continued on 8/21/18. (Px9B; Px13A).

Dr. Salehi testified via deposition on 6/26/18. He first saw the Petitioner on 3/23/17 on referral from Dr. Tu for the low back, as Dr. Tu is not a spine surgeon. The Petitioner reported his alleged 3/14/17 work accident and "a chronic history of lower back pain, but he called it low-grade pain prior to this injury", which Petitioner indicated went back to when he was struck by a car at work. Petitioner indicated on 3/14/17 that he "fell at work down the stairs, injuring his elbow and low back." Dr. Salehi testified he determined that Petitioner was a lumbar fusion candidate. He testified that 80% to 90% of patients with low back pain due to degenerative disease get better with conservative care and time, but they become fusion candidates if they don't get better and remain in moderate to significant pain. He testified that Petitioner's 2017 lumbar MRI showed an L4/5 annular tear causing mechanical back pain and conditions of disc disease and then the disc bulge as a result of the tear. He agreed that it was a disc bulge and that disc material had not necessarily herniated. The tear caused axial back pain, not radicular pain, and the axial pain is due to the tear impacting sensory nerves on the disc surface. (Px8; Px9).

Dr. Salehi testified he generally will bring up possible surgery after 6 months of conservative care (therapy, injection(s), and time) without a satisfactory resolution. If the patient at that point declines surgery, there would be an MMI determination and recommendation for functional capacity evaluation (FCE). Petitioner's complaints were ongoing back pain at rest from two to three, going up to seven out of ten with activity, and Dr. Salehi's impression was Petitioner's improvement with conservative care was not significant. In January 2018, he complained that his condition was worsening, so Dr. Salehi recommended surgery. He did testify that Petitioner's complaints of pain radiation to the legs or the leg giving way was referred pain from the back and not radicular. (Px8; Px9).

Dr. Salehi opined that the incident of 3/14/17 was an aggravating event that worsened the Petitioner's preexisting low grade low back pain. He testified that he reviewed the Petitioner's 2012 MRI films as well and that the 2017 films showed a progression and worsening of his L4/5 disc condition. He testified that a fall on the stairs could easily have aggravated the disc, as it was already in a worsened state, and that Petitioner reported an increase in his symptoms versus prior to 3/14/17. He testified that Dr. Bicek's report of Petitioner complaining of low back pain ranging from 2/10 to 5/10 in February 2017 does not impact his opinions. Asked if the changes shown on MRI was a natural progression or one that could have been caused by trauma, the doctor testified: "Either/or. I mean, I guess it would be impossible to say one way of the other, but both would be a competent cause of that progression." As to Petitioner's complaints of increased pain bending over to pick up a litter box, Dr. Salehi testified that "any forward flexion posture puts more pressure on the disc and loads up the disc, and they would have more symptoms from it." Pending surgery, he testified that Petitioner was unable to do his regular job. (Px8; Px9).

On cross-examination, Dr. Salehi acknowledged he was not told when the Petitioner had been struck by a car and testified that the Petitioner did not inform him that he had previously discussed lumbar surgery with a surgeon. His impression was that only conservative care had been considered at that time. While he agreed this is information he would want to know, he denied that this impacted his causation opinion. He first learned Petitioner had undergone a prior lumbar MRI when he brought a CD of the 9/26/12 films into his office on 10/17/17, which Petitioner acknowledged in his testimony. Dr. Salehi agreed Petitioner's primary pre-accident

diagnosis for his preexisting back pain was degenerative disc disease, and he agreed that this is a condition which slowly progresses over time. He again indicated it is impossible to determine if degeneration seen on MRI is due to this progression or a trauma, so he isn't surprised to see it in the regardless of trauma. (Px8; Px9).

Dr. Salehi testified that Petitioner just told him he had a fall on the stairs and had pain in his elbow and back. He wasn't any more specific than that, including whether he had symptoms immediately or within days afterwards. He did not know how many stairs he fell down, but assumed it was more than one: "It wasn't like he just missed the step. He came down – he came down on the body, and it's like he may have taken the blow with his arm." He testified that back pain from a trauma can take a few days to occur, or Petitioner's elbow injury severity could have masked a back injury. Dr. Salehi corrected his direct testimony, where he agreed he'd held Petitioner off work early on, testifying that he hadn't done so, and that Petitioner continued to work so he could make money. Respondent's counsel pointed out that Petitioner had been working up to the point he saw Dr. Salehi that he wasn't hurting for money at that point, and Salehi testified he was still having symptoms. He initially issued work restrictions on 7/19/17, noting Petitioner had been unable to drive after he started taking Tramadol. Dr. Salehi testified he took Petitioner off the drug at that point, as he "usually don't like patients on narcotics for chronic back pain." He testified he started Petitioner on Celebrex, and as to why he then continued to hold him off driving despite ending the narcotic medication, Dr. Salehi testified that if the company vehicle involves bouncing up and down, that is what he was actually restricting, not general car use. He acknowledged Petitioner indicated he was continuing to take Tramadol on 11/14/17, testifying he wasn't prescribing it and possible Dr. Farag was. He agreed he had not spoken to Dr. Farag about Petitioner nor had reviewed any of Farag's records. He testified that SI joint injections may have been prescribed by Dr. Farag, and when the injection failed it indicated "they were barking at the wrong tree." (Px8; Px9).

Dr. Salehi was not aware Petitioner had multiple February and March 2017 workers' compensation claims until he was informed of it by Petitioner's attorney on the day of his deposition, and he was not aware of any pre-3/14/17 medical records. Dr. Salehi agreed that other events, such as lifting a cat litter box, could "aggravate" Petitioner's back condition, but that when it comes to the accident itself, what he means by "aggravation" is Dr. Salehi explained that his definition for aggravation for a preexisting condition is "something that materially changes the spine so the pain keeps going, you know, at the high level." The more minor events are something that increases pain at that moment but is temporary. He did not see any Waddell signed regarding Petitioner. Dr. Salehi acknowledged that the issue of causation can be complicated when there are multiple reported accidents. (Px8; Px9).

10/15/18 pre-op testing with Dr. Bicek indicated no contraindications to surgery. (Px9B). Petitioner testified he was continuing to take medication and use a lidocaine cream but that they did not really help. He was continuing to have pain up to 6/10 to 7/10 with exertion and a return to 3/10 at rest. He reported no real social life due to pain and lack of funds. Petitioner testified the planned 10/31/19 surgery was being authorized via his group health carrier.

Subsequent to his 10/19/18 testimony, surgery was performed by Dr. Salehi on 10/31/18 involving decompression and fusion at L4/5, and including facetotomy, discectomy and arthrodesis of the endplates. Post-operative diagnosis was an L4/5 annular tear resulting in mechanical back pain and degenerative disc disease. (Px9B; Px17).

Petitioner testified he was continuing to follow up with Dr. Salehi through the time of his 10/11/19 testimony. On 11/13/18, he indicated to Dr. Salehi that he was taking up to 10 to 12 Norco per day with low back pain. Dr. Salehi advised him to limit this to 6 and increased his Robaxin frequency and ordered physical therapy to begin. Petitioner was continued off work, noting at the next visit he was to be released to light duty, which was to last

for 6 months post-operatively. (Px9B; Px13B). Therapy at ATI was reinstituted starting on 11/21/18. (Px13B; Px15)

On 12/27/18, Petitioner reported he was doing very well with little if any pain. He was not taking any medication but "does admit to having smoked a couple of cigarettes recently." He was to continue therapy for 6 more weeks and was released to light duty (no lifting over 20 pounds, no push/pulling over 35 pounds, no bending/twisting more than 3x per hour, and alternate sit/standing every 30-45 minutes as needed). (Px13C).

Interestingly, a Modified Oswestry Survey completed at ATI indicates Petitioner reported his pain was bad and he could only lift very light weights, though he didn't need to take medication. His pain prevented him from sitting more than a half hour or standing more than an hour. (Px15A). ATI indicates the Petitioner was discharged from therapy by Dr. Salehi as of 2/4/19., though it is unclear why as he was showing improvement and had not yet reached all of his planned goals. Therapist Nicole Milnamow's note states: "The patient did not meet the remainder of the long-term goals because: The patient has reached maximum medical benefit from therapy and has been discharged from therapy." (Px13C; Px15).

On 2/6/19, Petitioner reported he was doing very well with no pain at all, just tightness and muscle pain into the bilateral hips. He denied leg pain or paresthesias. He was to continue home exercise and light duty restrictions. On 3/21/19, Petitioner was doing well, noting some sharp low back pain when he wakes up that resolves once he stretches. He denied leg pain or numbness and he remained non-smoking. He was performing home exercise and trying to stay active. Home exercise and light duty restrictions were continued pending healed fusion, after which work conditioning was planned. (Px13C)

Documentation dated 7/29/19 indicates that the Petitioner was applying for Social Security Disability. However, it appears that documentation completed by Dr. Salehi on 8/14/19 indicated very little expected limitations on Petitioner's abilities. (Px13C).

Petitioner acknowledged a prior work injury to his low back when he was struck by a car in August 2012. A 2015 Hearing was held on the issue of a herniated disc versus an annular tear versus a strain. He received TTD, but treatment was in question. Petitioner returned to unrestricted work duties on 11/25/12. He was still in pain, but Dr. Mollsen told him the pain wouldn't go away overnight and said to wait a year and see how he did. He treated at DuPage. He went back after a year, late 2013.

Petitioner testified that he is required to return to work within two years of being off work in order to remain in his position.

On cross-examination, Petitioner testified supervisor Ryan closed the door almost immediately after he reported the slip and fall on the stairs, and that he was taking photos of the stair areas outside the office, at the landing and on the ground floor. Petitioner testified he didn't tell Ryan where on the stairs he fell before Ryan went to take photos. He agreed he only told Ryan he hurt the left elbow on 3/14/17 and didn't complete any paperwork that day 3/14, testifying he is left-handed and wasn't able to use the left arm to write. However, when he was shown Rx6, he agreed the documentation was in his handwriting and signature but did not recall writing anything on 3/14/17. Petitioner says he wasn't provided with this documentation in a FOIA request sent to Respondent. While Don Ryan testified he took photos using a cell phone, Petitioner reiterated that Ryan was using a camera when he took the photos.

As to his back condition, the Petitioner testified that at the doctor's office on 3/14/17 his elbow was in severe pain. He acknowledged he still was having some back pain from the prior incidents but couldn't say if his back pain was worse that day. When his elbow pain subsided, he noticed his back hurting.

Petitioner testified that Slack and Berardi were about 10 to 12' away when he fell, and he assumed they would have seen or heard him fall. He may have said something to them as they did turn and acknowledge him, but he testified he was embarrassed and got up pretty quickly, so they didn't come help him. He may have asked if they saw what happened. He fell forward and his entire body was on the stairs, testifying he came down on his side across 4 or 5 stairs. He may have sat down on the steps before he arose. After he fell and he looked back, there was water on the floor. He listed Berardi and Slack as witnesses because they were present. He testified that one of them may have asked if he was alright. He didn't say anything to them about his left elbow.

Petitioner indicated he didn't have further treatment following the 2/5/17 incident because he was told he had bursitis and was advised to return to work, and the Respondent wasn't approving physical therapy. He did not recall whether he had been informed that it wasn't being approved on 3/14/17 before going into the garage. He was wearing the seatbelt on the street sweeper but testified the seat itself goes up and down along with the seatbelt. He estimated he rose 8 to 12 inches up to hit his head on the roof.

Regarding his 2012 back injury, Petitioner acknowledged that surgery was denied in 2014 or 2015. He testified he changed his diet and started working out at that point and got back in great shape prior to these work incidents. He did tell Salehi he had a prior back injury years before, but otherwise indicated he had typical aches and pains that everyone has from various activities, but nothing that would prevent him from his routine. He testified he wasn't sure if he told Dr. Salehi that Dr. Deutsch had recommended disc replacement surgery. He did tell Dr. Salehi he had severe back pain in 2012, and he probably said he had surgery prescribed at that time. He agreed he didn't return to Dr. Deutsch again after his request for surgery was denied after a hearing.

Petitioner agreed on further cross that he had been mugged and car jacked on 4/19/17, where he was thrown to the ground, got kicked in the head a few times and had his wallet and car stolen. He believed it was the same day he had his MRI. He reiterated that he continued working without restrictions both before and after 3/14/17 until August 2017. He testified he may have told co-workers he was having problems while continuing to work between March and August 2017, but he agreed he never told Don Ryan about back problems between 3/17 and 8/17. Asked for more detail about the alleged accident on cross, Petitioner testified he didn't think his left boot made it onto the step, it was on the edge. The stairs are concrete, not marble like the floor.

Petitioner testified he last communicated with Lorenz Slack in October 2017 when he asked if he had given a witness statement because he had tried to obtain Slack's and Berardi's statements via a FOIA request. He testified that Berardi called him the night before his testimony asking where he had to go. That was the only discussion they had. He testified that he did text Slack a few weeks before the hearing to let him know his attorney was likely going to subpoena him to testify and he never got a response.

Petitioner agreed he used a phone to videotape himself sliding across the floor at his workplace in Spring of 2018, indicating the floor was in the same condition it had been in at the time of the accident, as he told Don Ryan his claim was being denied and he wanted to show the area was slippery even when it was not wet. He did the area by the stairs and the upstairs floor. He no longer has that video because his phone it was on was taken when he was mugged. He did show it to his dad.

As to the handwritten note signed by Petitioner, which stated 3/14/17, he testified he was asked to complete it by his boss to document what occurred. As to his indication of slipping at the bottom of the stairs, he testified he believed he got up facing the bottom of the steps and saw the boot prints at the bottom of the stairs, and this is what he was referencing. On redirect, Petitioner wasn't certain when he wrote the handwritten note dated 3/14/17. He came in to complete the incident forms and medical release on 3/15/17, and Don Ryan actually

wrote it out for him. When he returned to work the following Monday, he may have given his statement. He indicated 3/14/17 as the date of the injury, not an indication of when he wrote it.

He testified he continued to perform the weightlifting and cardio routine he had been doing from early 2016 after he fell on the stairs, as it helped his symptoms, though he said he eased up on the weights after the initial 2017 back injury. His back got worse after the fall on the stairs and he stopped doing exercises that would harm his back.

On rebuttal following Mr. Ryan's testimony, Petitioner again denied that supervisor Ryan gave him paperwork to complete on 3/14/17, reiterating that he closed the door on him and then walked by him when he came back out to take photos, and other than Ryan advising him to contact Corvel when they returned to the office, they had no other conversation. He testified that Ryan ultimately asked him the questions and filled out the accident report for him, around 6:30 a.m. on 3/15/17, because he couldn't do it himself do to his left elbow injury, and that the form (Px6) indicates he reported injuring both his elbow and his low back to Don Ryan while they were completing Px6, not just the elbow. The Petitioner reiterated that his boots were wet when he came in the building on 3/14/17 to refill the truck with salt and fuel, and that there had been other times that day where he had to get out of the truck and got wet.

Petitioner also testified that he was very familiar with the street sweeper machine, as he would drive it approximately twice a month for 10 years, and that the seat in that machine had a slow air leak. There was a button he would have to use to add air every 10 to 15 minutes, but on that day it had been deflating, and the pothole he hit was big enough that it caused him to go up and strike his head on the roof before coming back down onto a seat with no air in it. He testified that the machine had a lot of problems and was out of service a lot.

Cross-examined, the Petitioner testified he prepared the documentation in Rx6 a number of days after 3/14/17 at the request of the Respondent, and he put the 3/14/17 date on it because that was the day he was injured, and he gave this documentation to either Mr. Ryan or Mr. Cassman within a week of the alleged accident. He indicated that after Ryan slammed the door in his face, he didn't ask him why he was taking photos at the wrong locations because he didn't want to agitate him any further. He testified he knows he said some profanities when he fell on the stairs and had a severely injured elbow, but he got up relatively quickly because he was embarrassed about falling. As to the street sweeper, Petitioner testified they go no more than 10 miles per hour while sweeping is occurring, but he was driving at highway speeds on the way back to dump when he hit the pothole. He had no records of maintenance to the sweeper.

Between the time of his October 2018 testimony and his updated testimony on 11/14/19, the Petitioner testified he'd undergone the 10/31/18 lumbar fusion surgery with Dr. Salehi, and believed he had therapy at ATI from the third week of November 2018, with progressing activities, until his 2/4/19 discharge. He testified that on 3/21/19, Dr. Salehi felt healing of the fusion was not yet complete. While Dr. Salehi recommended work conditioning along with a home exercise program when physical therapy ended, Petitioner testified he did not attend work conditioning because no one was paying his bills and he didn't feel he was ready for it at that time. As his bills were not being paid, he told Dr. Salehi he wanted to do his regimen at his own gym, as he already knew all the exercises he had been doing, and that Dr. Salehi told him this was okay. Petitioner testified that he mainly did a lot of stretching and mainly leg presses, resistance band training, rowing machine type motions and wall squats, including with a medicine ball.

Petitioner testified he was released from Dr. Salehi's care on 7/23/19, and that he asked him to release him as of 8/12/19, which he did, and Petitioner returned to his unrestricted job duties on 8/12/19. He testified that since he returned to work, he has been a little more cautious than before and that he now does ask for help if needed,

mainly with heavier lifting. Petitioner testified he did not receive TTD while off work but did receive disability benefits through his retirement benefit program, indicating this could be replenished "one way or another." He has no pending appointments but planned to see Dr. Salehi for a 6-month follow up in February or March 2020. He continues to work out at his gym prior to going to work at 7 a.m., and this includes walking, stretching and light lifting.

The Arbitrator reviewed the surveillance video presented by Respondent covering three dates: 9/26/17, 2/14/18 and 2/17/18. All begin at what appears to be Petitioner's apartment complex parking lot. On 9/26/17, the Petitioner was seen at approximately 10:12 a.m. walking to his car. He gets inside and can be seen twisting to his right twice to reach into the back seat to perform some activity while seated in the driver's seat. It is difficult to see what exactly is happening inside the car. The Petitioner is then seen bending from outside of the car to reach to the floorboards of the driver's, passenger's and rear seats to pick up trash. He then drives to buy cigarettes at approximately 10:16 a.m. The next activity depicted is Petitioner arriving at Dr. Farag's office at approximately 10:50 a.m. After leaving at 11:23 a.m., Petitioner is seen driving to O'Reilly Auto Parts and then to a Menards or Home Depot. However, he is not shown doing anything beyond walking into the auto parts store. He returns to the apartment at 12:14 and no further video is depicted. The total amount of time filmed was 12:34. (Rx5).

Petitioner is seen briefly walking to his car and moving it within the lot at 11:06 a.m. on 2/14/18. He is seen on 2/17/18 very briefly returning to the apartment complex and backing into a spot. Each of these videos were just over 4:30 long and they show no activity of Petitioner. (Rx5).

Petitioner's prior workers' compensation claim against the Respondent regarding the 8/1/12 incident where he indicated he was struck by a car was identified as case number 12 WC 29972, and the Respondent submitted the arbitrator's decision in that matter as Rx3. The Arbitrator notes that the factual findings included in that case indicate the Petitioner sought treatment for his low back and left knee and had a disc replacement surgery recommended by orthopedic surgeon Dr. Deutsch. Arbitrator Kane in that case noted the dispute was based on the Petitioner undergoing three months of care for the low back, after which he returned to full duty work on or about 10/30/12. Over a year later he was noted to have returned to doctors with low back complaints. Petitioner saw Dr. Deutsch on 8/27/14. Arbitrator Kane noted that Dr. Deutsch was the only physician who described Petitioner's condition as involving a disc herniation. He disagreed with the diagnosis of a lumbar strain at the time of the 8/1/12 incident based on Petitioner's stated history that conservative treatment had not been effective and that "the symptoms never resolved other than for short periods of time." (Rx3).

Arbitrator Kane determined that the history indicated in the Petitioner's treatment records following the accident were inconsistent with what he told Dr. Deutsch, i.e. that conservative treatment had not improved his condition and he had ongoing pain after October 2012. The arbitrator found it not credible, along with the idea that Petitioner had continued to perform his heavy work duties routinely while having ongoing significant pain ("It is described as a heavy duty job and it would not be possible for the petitioner to work in such a position for more than a year with complaints and not see a doctor, especially since he was already seeing a doctor for a knee injury and attending physical therapy for approximately two months in 2013. Most critically, the petitioner freely testified that there was an unspecified time when his symptoms began again."). The arbitrator noted that Petitioner's indication that he began to experience pain in his back again at some point contradicted his claim that his back problems had never resolved after August 2012. (Rx3).

Petitioner testified that he still has unpaid medical expenses which he alleges are related to one of the accidents involved in the consolidated claims. His alleged expenses are contained in Px18 through Px25 and Px27.

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 testified essentially that he sustained a repetitive trauma injury that occurred over one or two hours on 2/5/17 while he was using an 18" chainsaw to cut trees and brush from highway walls. He testified the saw weighed 20 pounds and he was using it from approximately 8 a.m. to 10 a.m. He testified he became uncomfortable from being "hunched over" carrying the saw around and had severe pain in his bilateral low back when he tried to stand up straight. He testified and acknowledged that he'd had prior low back pain but had no such pain when he reported to work that day. He reported the injury to Phil Cassman that same day. He testified that Corvel, the Respondent's medical administrator, initially advised him to use ibuprofen and ice for a couple of days, which he did while continuing to work. When his pain didn't resolve he again contacted Corvel the following Thursday. He testified that he wanted to go to the Back Institute for treatment but Respondent would only authorize him to see Dr. Bicek.

The history of injury Petitioner provided to Dr. Bicek on 2/14/17 was that he was using a chain saw to cut trees for an hour or two on 2/5/17 and developed low back pain, he continued to work and three days later had an increase in pain that had not resolved since, with a pain level from 2/10 to 5/10. There were no neurological symptoms or findings indicated. Petitioner told Dr. Bicek he didn't want to be in light duty at work, but nothing else was noted in these records regarding a recommended work status. Acute low back pain without sciatica was diagnosed and Naproxen and rest were prescribed. While Petitioner testified that Dr. Bicek prescribed physical therapy, which isn't indicated in the records, and acknowledging he requested a release to return to full duty and continued to do so.

The Arbitrator finds that the Petitioner sustained accidental injury to the lumbar spine on 2/5/17, and that the pain he suffered at that time was causally related to the 2/5/17 accident. However, the Arbitrator further finds that this incident involved a temporary aggravation of a longstanding preexisting lumbar condition. The action of carrying around and operating a 20-pound chainsaw while walking down a highway appears to the Arbitrator to be an activity which clearly involves an increased risk of a low back injury. While there was no specific incident the Petitioner could point to, and while any repetitive trauma took place over the course of an hour or two, the Arbitrator believes the nature of this activity constitutes a compensable accident pursuant to the Act based on the activity being part of the Petitioner's job as a direct assignment from Respondent and the activity involving an increased risk of injury which arose out of his employment using and carrying a heavy vibrating power tool.

While the Arbitrator finds the claim compensable, the Arbitrator further finds that the Petitioner's accidental injury resulted in a temporary aggravation of his preexisting low back condition. The Petitioner originally injured his low back at work in 2012 when he indicated he was struck by a moving car which then came back and ran over his foot. As noted above, that matter went to hearing and the prior arbitrator indicated Petitioner sought treatment for his low back and left knee and ultimately had a disc replacement surgery recommended by surgeon Dr. Deutsch in August 2014. Arbitrator Kane in that case noted the dispute was based on the Petitioner undergoing three months of care for the low back, after which he returned to full duty work on or about 10/30/12, then over a year later returned with ongoing low back complaints.

In this case, as noted above, the facts indicate the Petitioner sustained a relatively minor injury to the low back. He was treated one time, which was 9 days after the accident date, and then requested and continued to work his regular duty job, which he testified to as being quite heavy at times. He continued to work and ultimately

claimed two additional low back injuries on 2/27/17 which he reported was due to hitting a pothole and jarring his back while driving a street sweeper and on 3/14/17 which he alleges was due to a slip and fall while starting to go up a stairway at work.

The Arbitrator finds that the greater weight of the evidence supports that the Petitioner sustained a temporary aggravation of his preexisting low back injury on 2/5/17 which had resolved prior to his alleged 2/27/17 low back injury.

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:

In reviewing the Petitioner's claimed unpaid medical expenses, admitted into evidence as Px18 through Px25 and Px27, While the Petitioner claims outstanding medical expenses totaling $27,320.52, the Arbitrator notes these expenses are claimed in all three presented consolidated claims and the exhibits don't specify which accidents the bills are alleged to be related to.

The Arbitrator's review of these exhibits do not appear to be related to the 2/5/17 accident. Therefore, the Petitioner's claim for medical expenses related to this claim are denied.

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

The Arbitrator finds that the records of Dr. Bicek do not reflect any recommended medical treatment. The records state that Petitioner asked to return to his full work duties. He had no follow up treatment until the alleged 2/27/17 accident that is the subject of 17 WC 08104 and the 3/14/17 accident that is the subject of 17 WC 08105. As there are no pending prospective treatment recommendations that would reasonably be considered to be related to the 2/5/17 accident, the Arbitrator denies the request for prospective medical authorization.

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

The Arbitrator finds that any claimed outstanding TTD benefits by Petitioner are not related to the 2/5/17 accident. Per Arbx1a, Petitioner claims entitlement to TTD from 8/18/17 through 9/27/18. This period, if related to any claim, would appear to involve Petitioner's claimed 3/14/17 accident. Following the 2/5/17 accident, the Petitioner asked and continued to work his regular duty job, which he continued to perform until well after the alleged 3/14/17 accident, which is also alleged to involve the lumbar spine. The Arbitrator denies the Petitioner's claim for TTD benefits related to the claim at bar.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that while Penalties and Attorney Fees were indicated as a possible issue in the Request for Hearing form, Petitioner's counsel indicated that this was an undetermined issue and that it would be determined post-hearing whether a Petition for Penalties and Fees would be filed. The Arbitrator has not received such Petition, and as a result the Arbitrator finds that this issue has been waived. The Arbitrator would

Phillips v. Illinois State Toll Hwy Auth., 17 WC 35924

also note that Sections 19(k) and 19(l) do not otherwise appear to be applicable in this case based on the greater weight of the evidence submitted.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC022516
Case Name	CHIARELLI, ANGELO v. INTERNATIONAL EAGLE XPRESS INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0181
Number of Pages of Decision	13
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Richard Victor
Respondent Attorney	Charlene Copeland

DATE FILED: 4/21/2021

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

Angelo Chiarelli,

Petitioner,

vs. NO: 18 WC 22516

International Eagle Xpress, Inc.,
and the Illinois State Treasurer as *Ex-Officio* Custodian
of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employment relationship, accident, notice, notice of hearing to the employer, causal connection, medical expenses, temporary total disability, and permanent disability, and being advised of the facts and law, vacates the Decision of the Arbitrator and remands the matter to the Arbitrator for trial on the merits with proper notice of the same.

I. FINDINGS OF FACT & PROCEDURAL BACKGROUND

On December 13, 2019, an *ex parte* arbitration hearing was held relating to Petitioner's claimed accident date of November 4, 2016. Present at the hearing were Petitioner, his attorney, and the assistant attorneys general representing the Injured Workers' Benefit Fund ("Fund"). Respondent International Eagle Xpress, Inc. ("IEX") was not present and was not represented by counsel. All issues except penalties and fees and credit due were in dispute.

Petitioner submitted Petitioner's Exhibit ("PX") 1 into evidence, and the Arbitrator admitted the same. Said exhibit was a letter dated September 17, 2019 from Petitioner's counsel to IEX, mailed to 819 Thorndale Ave., Ste. 900 in Bensenville, IL. The letter was sent certified mail informing IEX of the hearing date of the above-captioned matter. The exhibit also contains the certified mail receipt as well as a note from the U.S. Postal Service dated September 23, 2019: "Return to Sender, No Such Number, Unable to Forward." The Application for

Adjustment of Claim filed with the Illinois Workers' Compensation Commission on July 31, 2018 also names IEX as the Respondent and lists 819 Thorndale Ave., Ste. 900 in Bensenville as IEX's address.

In response to PX1, the Fund noted that the alleged accident date was November 4, 2016, and that IEX was dissolved on November 30, 2016. Thus, the Fund argues that Petitioner attempted to serve notice on IEX nearly three years later at its previous address. At the hearing, the Fund requested that Petitioner serve Respondent IEX's agent, located at a different address than IEX's previous address. However, the Arbitrator commenced a hearing and, after admitting PX1, allowed Petitioner to proceed with his case in chief.

The Arbitrator rendered a decision filed on June 15, 2020. In the conclusions of law, the Arbitrator found that Petitioner did not properly serve notice upon IEX, thereby infringing upon IEX's right to due process. The Arbitrator noted that the purpose of providing notice and requiring notice procedure to be followed is to allow the parties an equal opportunity to be made aware of an impending trial date so they may be able to present their respective side of the case on said date prior to the issuance of an arbitration decision.

Here, the Arbitrator noted that notice of the hearing was returned as "undeliverable," and that the Fund produced evidence from the Secretary of State indicating that IEX had a registered agent located at 7324 W. Lawrence Ave., Hardwood Heights, IL 60706. The Arbitrator noted that Petitioner should have exhausted all efforts in properly serving IEX by serving the registered agent, whose name and current address are readily available. The Arbitrator found that failure to attempt to serve notice upon the registered agent's address was tantamount to infringement of IEX's right to due process.

The Arbitrator also found that IEX failed to maintain adequate workers' compensation insurance based on evidence submitted by Petitioner at trial. However, due to Petitioner's failure to prove notice, an essential element of his case, the Arbitrator denied Petitioner benefits under the Act and found all other issues to be moot.

Petitioner filed a timely petition for review on June 24, 2020, specifically claiming notice to the employer as an issue. Both Petitioner and the Fund filed briefs in support of their positions on the issues on review. In addition to arguments on the merits of the case, Petitioner argues that he relied on the Arbitrator's admittance of PX1 over objection in proceeding against IEX *ex parte* and the Fund argues that Petitioner failed to exhaust efforts in properly serving Respondent IEX.

II. CONCLUSIONS OF LAW

Petitioner and the Fund both assert, on review, that Respondent IEX was not properly notified of the hearing. The Commission agrees.

It is the obligation of the Petitioner to provide the appropriate address to the Commission so that proper notice can be sent to the opposing party(ies). "Once an Application is filed, the Commission will send the information on the Application, on a Notice of Hearing, to the opposing party at the address supplied by the filing party. If the Notice is returned to the Commission because the filing party has supplied the wrong address for the opposing party, the Commission will so inform the filing party. The filing party has the obligation of providing the Commission with the proper address so Notice can be sent to the opposing party." 50 Ill. Adm. Code 9020.20(d) (2016).

The Rules Governing Practice Before the Illinois Workers' Compensation Commission also provide the procedure to request a trial date certain. Cases that have been on file at the Commission beyond three years appear on the monthly status calls. 50 Ill. Adm. Code 9020.60 (2016). Thereafter, "[a] written request for a date certain for trial may be made by any party at the monthly status call on which the case appears." 50 Ill. Adm. Code 9030.20(a) (2016). Section 9030.20 states in pertinent part "[i]f any party fails, without good cause, to appear, the Arbitrator will hear the motion for trial date ex parte and, if the Arbitrator determines the matter is ready for trial, will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify the opposing party of the trial date." 50 Ill. Adm. Code 9030.20(c)(2) (2016).

Moreover, the Illinois Supreme Court has addressed whether the Commission has jurisdiction over a matter in consideration of due process to the parties. In *Interstate Contractors,* the Supreme Court found that the "Commission and the circuit court are vested with the power to examine the validity of the decisions entered in the proceedings below and empowered to determine whether they are void for lack of jurisdiction over the parties." *Interstate Contractors v. Industrial Comm'n*, 81 Ill. 2d 434, 438 (1980). Addressing a somewhat different procedural history, but where a respondent had not, in fact, received correspondence from the Commission in his capacity as an officer of the respondent corporation, the court held that "section 19 of the Act does not authorize the entry of a decision in violation of the principles of due process." *Id*.

In this case, there is no evidence that Respondent IEX was notified by Petitioner, or by extension by the Commission through official notices, of the arbitration hearing date. It is apparent that the Arbitrator determined that the case was ready for trial regardless of its age, and that the only address known to the Commission, provided by Petitioner in his filed Application for Adjustment of Claim, was likely invalid at the time of notice by Petitioner, or official notice by the Commission, should have been given about the arbitration hearing date. Indeed, the publicly available State of Illinois online database referenced by the Fund reflects that Respondent IEX dissolved on November 30, 2016. As such, the Commission finds that Petitioner failed to provide proper notice in accordance with his responsibilities to Respondent IEX, and that the Commission was without accurate information about Respondent IEX such that its notices might have properly alerted IEX about its obligations to appear.

Petitioner failed to follow the Commission's rules providing proper notice to Respondent IEX about the hearing date, service of related forms, or keeping the Commission apprised of any amendments to IEX's information contained in his original Application for Adjustment of Claim such that the Commission could provide proper notice to all interested parties to Petitioner's case. Serving IEX at its last known business address, in this case, denied due process to IEX because Petitioner was aware, or should have been aware, in 2019 that IEX had dissolved less than 30 days after the claimed accident, years prior to attempting to serve notice of the hearing.

In consideration of the record as a whole, the Commission finds that proper notice was not effectuated on Respondent IEX in violation of its due process rights. Requiring notice to all named parties ensures due process under the law and there is no evidence that Respondent IEX received proper notice in this case divesting the Arbitrator of jurisdiction at the time of the December 13, 2019 hearing. The Commission finds that the lack of proper notice to Respondent IEX renders the Arbitrator's decision void for lack of jurisdiction over the parties. Accordingly, the Commission vacates the decision of the Arbitrator filed June 15, 2020 and remands this claim back to an arbitrator for a new hearing on the merits with proper notice provided to all necessary parties.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 15, 2020 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to arbitration for a hearing on the merits with proper notice of the same.

No bond for removal of this cause to the Circuit Court is required as no award for payment has been entered. 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: **4/21/2021**
o: 3/4/21
BNF/wde
45

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0181

CHIARELLI, ANGELO Case# **18WC022516**

Employee/Petitioner

INTERNATIONAL EAGLE XPRESS INC AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND

Employer/Respondent

On 6/15/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0000 INTERNATIONAL EAGLE XPRESS INC
819 THORNDALE AVE
SUITE 900
BENSENVILLE, IL 60106

6197 ASSISTANT ATTORNEY GENRAL
PATRICIA JJEMBA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angelo Chiarelli Case # **18** WC **022516**
Employee/Petitioner
v.
International Eagle Xpress, Inc. and the 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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **12/13/19** . 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Is respondent IWBF liable? Was notice proper?**

FINDINGS

For the reasons outlined in the attached decision, the Arbitrator finds that Petitioner failed to effectuate proper notice upon Respondent-Employer International Eagle Xpress, Inc. The Arbitrator finds the remaining disputed issues moot and makes no findings as to those issues. The Injured Workers' Benefit Fund is not implicated as the Arbitrator makes no award.

ORDER

See the above and the attached decision. 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

05/15/2020
Date

JUN 1 5 2020

PROCEDURAL HISTORY

Petitioner, Angelo Chiarelli ("Petitioner"), pursued this action under the Illinois Workers' Compensation Act ("Act") seeking relief from Respondent-Employer, International Eagle Xpress, Inc. ("Respondent-Employer"). (AX 1) This action also sought relief from the Injured Workers' Benefit Fund ("IWBF") as Respondent-Employer did not maintain workers' compensation insurance coverage on the date of the accident. (PX 4) On December 13, 2019, the claim proceeded to hearing before Arbitrator Tiffany Kay. Attorney Richard Victor appeared on behalf of Petitioner. Respondent-Employer did not appear for the arbitration proceedings. The Office of the Illinois Attorney General appeared on behalf of the Illinois State Treasurer, as *ex officio* custodian of the IWBF, and also participated in the arbitration hearing through its attorney the Illinois Attorney General's Office.

Counsel for the IWBF noted on the record her objection as to the case proceeding to trial for lack of proper notice. Counsel argued that Respondent-Employer dissolved on November 30, 2016, per the Secretary of State's records. (RX 1) Petitioner sent notice to Respondent-Employer's last known address, 819 Thorndale Avenue, #900, Bensenville, Illinois 60106, via certified mail. (PX 1) The United States Postal Service ("USPS") returned notice to Petitioner as undeliverable, crossed out Respondent-Employer's address, and included the marking "NSN," which USPS utilizes to indicate No Such Number. *Id.* Secretary of State records identify BM Taxes & Accounting PC, located at 7324 W. Lawrence Avenue, Hardwood Heights, Illinois 60706, as the registered agent. (RX 1) Counsel for the IWBF argued that as such, Petitioner should have sent notice of the proceeding to the registered agent, whose address was distinct from that of Respondent-Employer. Petitioner's counsel asserted that his only obligation was to send notice to the Respondent-Employer's last known address. Arbitrator Kay overruled counsel's objection as to the notice issue and the trial proceeded to hearing. All issues were in dispute. (AX 1)

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that on November 4, 2016, he was a 65-year-old, married employee of International Eagle Xpress, Inc. He interviewed with the owner "Tom" on May 10, 2016 at Respondent-Employer's office, which was located at 819 Thorndale Avenue in Bensenville, Illinois. He completed an application and contractual agreement. (PX 2) Petitioner began working with Respondent-Employer as a truck driver in late May 2016. As a truck driver, Petitioner consistently received delivery assignments from Respondent-Employer's dispatcher. His truck driving duties included driving a thirteen-speed Volvo truck to deliver United Nation t-shirts from Illinois to California. Respondent-Employer's name was printed on the outside of the truck. Petitioner earned 55 cents per mile, which amounted to approximately $2,000.00 a week. He drove approximately 77 hours per week. Respondent-Employer paid Petitioner by check and did not withhold taxes. Petitioner testified that he paid taxes on his own and that was typical in the truck driving industry.

On November 4, 2016, between 5:00 a.m. and 6:00 a.m., Petitioner was returning to Illinois after delivering a shipment for Respondent-Employer in California. While driving through Atlantic, Iowa, Petitioner's steering wheel system malfunctioned, and his truck flipped over. He unbuckled himself in preparation to exit the truck. A United States Postal Office truck subsequently hit Petitioner's truck, causing the truck to explode. The impact caused Petitioner to eject from the truck. Petitioner suffered injury to both arms and shoulders. First responders, including Iowa State Police and United States Marshalls arrived to the scene. An ambulance transported him to Atlantic Medical Center ("Atlantic Medical").

Upon arrival at Atlantic Medical, Petitioner gave a statement to the Iowa State Police. While receiving medical care, Petitioner testified that he received a call from Respondent-Employer's dispatcher, whose name he was unable to recall. The dispatcher asked Petitioner what had happened, to which he responded by telling

the dispatcher how the accident had happened and the injuries he had sustained. He did not complete any paperwork for Respondent-Employer regarding the accident. Shortly after returning to Illinois, Petitioner called Tom and asked him for $5,000.00 for his pay. Tom hung up on Petitioner. Petitioner has not spoken to Tom or anyone from International Eagle Xpress, Inc. since the phone call with Tom. Petitioner did not receive pay for the delivery he made in relation to the date of injury. Respondent-Employer dissolved on November 30, 2016. (RX 1)

Petitioner treated for injuries to his elbows and shoulders through June 26, 2017, when he was released to work full duty. He returned to work full duty on March 28, 2017 at another trucking company. Petitioner is currently works a truck driver for Millenia Aero Corporation, where he earns $1,800.00 a week.

Medical Treatment

On November 4, 2016, Petitioner arrived at Atlantic Medical Emergency Room by ambulance. (PX 6) He underwent a full work up examination and received clearance to ride home to Illinois with his wife to receive treatment on his bilateral shoulders and left elbow. *Id.* Upon his arrival in Illinois, Petitioner saw his primary care physician, who referred him to Dr. Stephen Madry at Advocate Good Shepard Hospital (PX 7, 9) Dr. Madry performed a debridement on Petitioner's left elbow. (PX 9) Petitioner did not follow up with Dr. Madry. *Id.*

Petitioner's primary care physician referred him to Dr. Eugene Lopez for left shoulder treatment. (PX 11) In January 2017, diagnostic tests revealed a left shoulder grade three left acromioclavicular sprain, left acromioclavicular joint separation, and mild degenerative changes. *Id.* Petitioner engaged in a few weeks of physical therapy for the left shoulder but had to stop because the exercises were too painful. (PX 8) On February 10, 2017, Dr. Lopez performed a distal clavicle resection and joint reconstruction surgery on Petitioner's left shoulder. (PX 11) Petitioner engaged in another round of physical therapy for the left shoulder. (PX 8) Dr. Lopez released Petitioner to return to work full duty on June 26, 2017. (PX 11) Petitioner testified that his medical bills were paid through his wife's medical insurance.

Petitioner testified that he still has pain in his left shoulder when reaching above his head and lifting heavy items.

CONCLUSIONS OF LAW

As an initial matter, the Arbitrator notes Petitioner has the burden of proving his case by a preponderance of the evidence. *Chicago Rotoprint v. Industrial Comm'n*, 157 Ill.App.3d 996, 1000 (1987). Liability cannot rest upon imagination, speculation or conjecture. *See United Airlines v. Comm'n*, 991 N.E.2d 458, 463 (2013). The Arbitrator relies on Petitioner's testimony and the exhibits entered into evidence in making the following conclusions of law:

With regards to issue (O) whether notice was properly served upon Respondent – Employer, the Arbitrator finds as follows:

1. **Petitioner did not properly serve notice upon Respondent-Employer.**

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. After review, the Arbitrator finds that the Petitioner failed to properly serve Respondent-Employer, therefore, infringing upon its right to due process. The Commission has clearly stated that the "purpose of providing

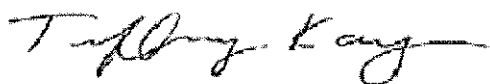
notice and requiring a notice procedure to be followed is to allow both parties an equal opportunity to be made aware of an impending trial date so they may be able to present their respective side of the case on said date prior to a determination by an arbitrator. Further, the Commission finds requiring notice ensures due process under the law." *Interstate Contractors v. Industrial Comm'n*, 81 Ill. 2d 434, 438 410 N.E.2d 837 (1980). The Commission ultimately found there to be no jurisdiction to hold an *ex parte* hearing due to lack of proper notice. *Id.* "Section 19 of the Act does not authorize the entry of a decision in violation of the principles of due process." *Id.* The Commission reiterated this reasoning in *Byron Rene Donis v. Claudio L. Radu/Juan Carlos Hernandez & IWBF*, when it found there was no evidence that Respondent received proper notice. *Byron Rene Donis v. Claudio L. Radu/Juan Carlos Hernandez & Illinois Workers' Benefit Fund*, 08 IL.W.C. 00798 (Ill.Indus.Com'n), 18 I.W.C.C. 0313, (2018). In that case, no address was provided for the first Respondent-Employer and an inaccurate address was provided for the second. *Id.* The Commission determined it was "the obligation of the Petitioner to provide the appropriate address." *Id. See also* Illinois Administrative Code 7020.20(d) (West 2007).

In this case, Petitioner sent notice of the December 13, 2019 hearing to Respondent-Employer at the following address, 819 Thorndale Avenue, #900, Bensenville, Illinois 60106, via certified mail. Yet, the mail returned to Petitioner as undeliverable with the USPS notation "NSN," indicating No Such Number with respect to the address. Furthermore, the IWBF presented evidence from the Secretary of State indicating that Respondent-Employer had dissolved on November 30, 2016, but that a registered agent located at 7324 W. Lawrence Avenue, Hardwood Heights, Illinois 60706 exists. Petitioner ultimately attempted to serve an entity that had been dissolved over three years prior to the date of hearing, at an address that USPS deemed not in existence. As such, Petitioner should have exhausted his efforts in properly serving Respondent-Employer by serving the registered agent, whose name and current address was readily available. Failure to even attempt to serve notice upon the registered agent's address was tantamount to infringement of Respondent-Employer's right to due process.

2. Respondent-Employer failed to maintain adequate workers' compensation insurance.

Respondent-Employer lacked workers' compensation insurance. The Illinois State Treasurer as *ex officio* custodian of the IWBF was named as a party respondent in this matter. Petitioner testified that he suffered injury on November 4, 2016. He submitted sufficient credible evidence that Respondent-Employer was not insured on the aforementioned date of accident. Such evidence consists of a certificate from the National Council on Compensation Insurance certifying that, based on NCCI employee Cristina Grandos's January 21, 2019 search, International Eagle Xpress, Inc. did not possess insurance on November 4, 2016. (PX 4) Therefore, the Arbitrator finds that given Respondent-Employer failed to maintain worker's compensation insurance on the date of injury.

Given this, the Arbitrator finds Petitioner failed to effectuate proper notice upon Respondent-Employer International Eagle Xpress, Inc. Additionally, the Arbitrator finds Respondent-Employer failed to maintain workers' compensation insurance. Despite this finding of fact, Arbitrator finds that Petitioner has failed to meet his burden to prove an essential element of his case as to notice. Benefits to Petitioner under the Workers' Compensation Act are denied. All other issues are moot.



Signature of Arbitrator

05/15/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028767
Case Name	COLEMAN, NICHOLAS T v. DSC LOGISTICS CO
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0182
Number of Pages of Decision	12
Decision Issued By	Christopher A. Harris, Commissioner

Petitioner Attorney	Bryan Shell
Respondent Attorney	Charles Maring

DATE FILED: 4/21/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS COLEMAN,

Petitioner,

vs. NO: 18 WC 28767

DSC LOGISTICS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, temporary total disability (TTD) benefits, and permanent partial disability (PPD) benefits, if applicable, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 7, 2020 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $68,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: **4/21/2021**

/s/ *Christopher A. Harris*

CAH/pm
O: 4/15/21
052

/s/ *Barbara N. Flores*

/s/ *Marc Parker*

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

COLEMAN, NICHOLAS
Employee/Petitioner

Case# **18WC028767**

DSC LOGISTICS
Employer/Respondent

On 1/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1,52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS & MANZELLA PC
BRYAN SHELL
19 W JEFFERSON ST
JOLIET, IL 60432

1120 BRADY CONNOLLY & MASUDA PC
CHARLES M MARING II
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

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)

Nicholas Coleman
Employee/Petitioner

Case # **18** WC **28767**

v.

DSC Logistics
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 **New Lenox**, on **December 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. ☒ Did an accident 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. ☐

FINDINGS

On the date of accident, **July 31, 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 $**33,998.88**; the average weekly wage was $**1,030.27**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **4** dependent children.

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

Respondent shall be given a credit of $**10,242.39** for TTD, $ **0** for TPD, $ **0** for maintenance, and $**1,881.52** for other benefits, for a total credit of $ **12,123.91**.

ORDER

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

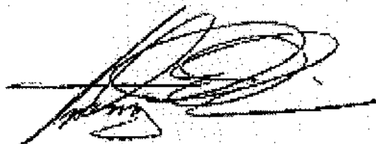
Respondent shall pay Petitioner temporary total disability benefits of $**686.85**/week for **69 3/7** weeks, commencing **July 31, 2018 through September 11, 2018 and September 18, 2018 through December 4, 2019,** as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective medical treatment for Petitioner's lumbar spine as recommended by Dr. Miz, Dr. Kusuma and Dr. Lorenz

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

January 2, 2020
Date

JAN 7 - 2020

FACTS:

On July 31, 2018, the Petitioner was employed by the Respondent as a machine operator/forklift driver/picker, and he had been so employed for approximately nine (9) months. The Petitioner was staffed in the Kellogg's warehouse picking special orders, which go to certain grocery stores. The Petitioner testified that he would palletize product to be shipped to various stores and that he had to stack 20-250 boxes, depending on the size of the product, from the bottom of the pallet to waist high. Petitioner testified that he had to pick up individual boxes ranging from floor height to waist height, and this palletizing activity required bending, pushing, pulling, stooping, twisting and turning while lifting the boxes that weighed approximately 25-100 pounds per box. The Petitioner testified that he worked alone and was not provided assistance while lifting. The Petitioner testified that after he stacked the pallets he had wrap them with plastic wrap. The Petitioner testified that wrapping the pallet required him to wrap the plastic wrap around once, tie it to one side and then go around the pallet approximately 30-40 times, bending and pulling the plastic wrap from the bottom of the pallet, which is inches off the floor, to about waist height. The Petitioner testified that he worked a twelve (12) hour shift, usually from six o'clock p.m. to 6 o'clock a.m., five days per week from Sunday to Thursday. He testified that he would build approximately 30 pallets per shift and move approximately 1200-2500 boxes per night.

The Petitioner testified that prior to July 31, 2018 he never had any back pain and had not received any medical or chiropractic treatment for low back pain. The Petitioner testified that he had been working for Respondent for nine (9) months, and did not have any difficulty performing his job duties nor did he have any complaints of back pain while performing his job duties.

Petitioner testified that on July 31, 2018 at approximately 9:00 p.m., three hours after the start of his shift, he was performing his normal job duties and was wrapping a pallet. Petitioner testified that, as he was bending over and twisting while he was wrapping the pallet, he felt a sharp pain in his back that went down into his right leg and fell to the ground. He testified that his supervisor, Brandon, was standing nearby. Petitioner testified that he reported the injury to Brandon and was told to go get water in the break room. The Petitioner testified that he stayed in the break room for approximately thirty (30) minutes, but still couldn't feel his right leg.

An ambulance was called, and the Joliet Fire Department came to the scene. The EMT records documented a 41-year-old male who hurt his back while he was wrapping a pallet, who had no history of back pain and has pain going down his right leg. The Petitioner was transported to Presence Saint Joseph Medical Center in Joliet. The history taken on the physician report stated that the Petitioner was 41-year-old with low back pain that radiates down the right leg since 9:00 p.m. He denied trauma, but stated that he was at work wrapping pallets when he started having the pain. He also stated that he makes repetitive movements at work and had never had problems with his back before. The Petitioner underwent an x-ray and was diagnosed as having a compression fracture at T-12. The Petitioner was given work restrictions and told not to return to work until cleared by his primary care or orthopedic physician.

The Petitioner then sought medical treatment with Primary Healthcare Associates-Orthopedics and he began treating with Dr. George Miz, a board-certified orthopedic spine surgeon. Dr. Miz took a history from the Petitioner noting that the Petitioner presents with low back pain secondary to a work-related injury. On July 31, 2018, the Petitioner was stacking pallets at work and felt a sharp

pain in his back. He was injured when he was wrapping a pallet and rotating around to his right. He had onset of low back pain radiating into his right leg. He had no history of back problems. After a physical examination, which revealed positive leg raise on the right. Dr. Miz diagnosed lumbago with sciatica on the right side and recommended Petitioner to undergo an MRI without contrast. Dr. Miz recommended Petitioner remain off work.

The Petitioner underwent an MRI on September 4, 2018. After review of the MRI Dr. Miz noted a disc bulge at L4-5 somewhat worse on the right causing bilateral foraminal stenosis somewhat worse on the right and a posterior annular HIZ (hyper intense zone). Dr. Miz recommended physical therapy and gave Petitioner a work restriction of sedentary duty, ten (10) pound lifting restriction, no bending or stooping.

The Petitioner started physical therapy at ATI on September 14, 2018. ATI noted a history from the Petitioner that he was wrapping a pallet and felt sudden pain in his right lower back that went into his leg.

The Petitioner testified that he tried to return to work with the restrictions, but the Respondent put him back to work which exceeded the doctor's restrictions. Petitioner testified that Respondent had him picking orders and cleaning, which was too difficult for Petitioner and above the sedentary duty with a ten (10) pound lifting and no bending or stooping restriction.

The Petitioner returned to Dr. Miz on September 18, 2018, the history noted at this visit indicates that his employer would not follow the restrictions and required him to perform his regular duties that exceeded his work restrictions. He reported that his pain worsened while performing these duties. Dr. Miz took Petitioner off work at that time.

Dr. Miz saw the Petitioner again on October 2, 2018 and noted that physical therapy was helping, but relief was temporary. Dr. Miz recommended Petitioner see a pain management physician.

The Petitioner was discharged from physical therapy on November 5, 2018, after attending seventeen (17) visits.

On November 8, 2018, Petitioner was examined at the request of the Respondent by Dr. Kern Singh at Midwest Orthopaedics at Rush. Dr. Singh agreed the Petitioner had a causally related work injury, but diagnosed a muscular strain. Dr. Singh opined the Petitioner could return to work and needed no further treatment.

Respondent obtained video surveillance of the Petitioner taken on the same day as the examination by Dr. Singh. The Arbitrator reviewed the video and notes that it shows the Petitioner walking in and out of a building, entering and exiting his vehicle, entering what appears to be his home/apartment complex and appearing on the back patio to sit and smoke for a short period of time.

The Petitioner was seen again by Dr. Miz on November 20, 2018 and December 4, 2018, where Dr. Miz noted that there is a known pathologic disc at L4-5 with asymmetric bulge towards the right causing foraminal stenosis which is consistent with his clinical picture. Dr. Miz continued his referral to a pain management specialist and kept Petitioner off work.

Petitioner then saw a pain management physician, Dr. Udit Patel at Pain & Spine Institute. Petitioner gave a history that he had no prior history with back pain and this started after a July 31, 2018 work injury where he was bending over. He also stated he was picking up boxes that could weigh up to 100 pounds and twisting/bending putting on a pallet. Dr. Patel examined Petitioner and diagnosed Petitioner with low back pain and radiculopathy. Dr. Patel wanted to see the MRI before recommending any further treatment.

On January 18, 2019, Dr. Patel was able to review the MRI, noting degenerative changes at L4-5, posterior disc bulge and narrowing of the inferior neural foramina. Dr. Patel recommended an L4 transforaminal epidural steroid injection. Dr. Patel performed two L4 transforaminal epidural steroid injections on January 30, 2019 and March 15, 2019. On March 15, 2019, Dr. Patel recommended that Petitioner consider spine surgery if he hadn't obtained long-term relief.

The Petitioner returned to Dr. Miz on April 9, 2019 reporting that he only had temporary relief from the injections and had returned to baseline even though the last injection was only two (2) weeks prior. Dr. Miz then went over the treatment options, which were to live with the pain, continue with more injections, or operative management that would be a right sided decompression with a transforaminal lumbar interbody fusion at L4-5. Dr. Miz did not perform surgical procedures, so he would be referred to his associate. Dr. Miz also continued Petitioner off work.

Petitioner was then sent by his attorney(s) to Dr. Mark Lorenz, a board-certified orthopedic spine surgeon, at Hinsdale Orthopedics. Dr. Lorenz noted a consistent history of the Petitioner's injury, where he was wrapping pallets and felt pain in his back. Dr. Lorenz diagnosed an L4-5 annular tear with lumbar back pain and right lower extremity radiculopathy secondary to work related injury on July 31, 2018. Dr. Lorenz concurred that he could proceed with an L4-5 PSF with instrumentation, allograft and autograft. Dr. Lorenz wrote an addendum to his IME on May 1, 2019 stating that he had reviewed video surveillance, and nothing observed was inconsistent with Petitioner's complaints and findings.

The Petitioner was then seen by Dr. Srinivasu Kusuma who recommended that Petitioner should undergo L4-5 decompression and PSF with TLIF. Dr. Kusuma kept Petitioner off work.

Dr. Mark Lorenz testified on June 24, 2019. Dr. Lorenz testified that the MRI findings could be summarized as degenerative, but the Petitioner had an annular tear with a hyperintense zone at L5-S1, which means there is inflammatory changes and/or fluid collections in that area. Dr. Lorenz testified that it is more likely than not that the twisting maneuver caused the annular tear and pain. Dr. Lorenz opined that the movement described by Petitioner with the onset of pain and the findings in the MRI and subsequent clinical exams are all consistent. He opined that the rotary loading movement while wrapping the pallet was the cause of the patient's current conditions.

Dr. Kern Singh also testified in this matter on April 3, 2019. Dr. Singh opined that the Petitioner sustained a soft tissue muscular strain and that his L4-5 disc protrusion was a radiographic finding alone and not clinically significant. Dr. Singh testified that the Petitioner was at MMI and needed no further medical care four (4) weeks after the injury. Dr. Singh did agree that physical therapy for four weeks and the MRI were appropriate, reasonable and causally related to the work injury. On cross-examination Dr. Singh agreed the Petitioner's MRI revealed disc pathology and that pathology can be

a pain generator. Dr. Singh also agreed that the activity Petitioner was performing at the time of his accident could cause a disc protrusion. Dr. Singh testified that he reviewed the surveillance and noted the Petitioner walked the same in his office as he did in the video.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner sustained an accident on July 31, 2018 when he was wrapping a pallet. The Petitioner was clocked in for three hours and had already picked, stacked and wrapped several pallets. He was not doing anything other than work duties when the injury occurred. The Petitioner was wrapping a pallet that was going to be shipped. The medical records introduced into the record provide convincing circumstantial evidence that the injury occurred as described by the Petitioner. The very first occasion the Petitioner had to give a history of the injury was to his employer, specifically the supervisor who saw what happened. The next occasion was the history given to the EMT from Joliet Fire Department, who noted that the Petitioner hurt his back wrapping a pallet. At the emergency room the doctor noted a history of wrapping pallets when he started having the pain. Respondent argues that in this same note the Petitioner denied trauma and that the triage department noted that the Petitioner was at work moving boxes and felt sharp pain that started in his lower back and moved down his leg, so these statements are inconsistent with Petitioner's reporting of the injury. On the contrary, they are completely consistent. The Petitioner stated what he does at work, which is moving boxes to build a pallet, but when asked when the pain started, he remained consistent in saying that it occurred when he was wrapping a pallet.

The Arbitrator finds that on July 31, 2018, the Petitioner sustained an accident which arose out of and in the course of his employment with the Respondent while he was wrapping a pallet and felt pain in his back that went into his right leg.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

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. The Arbitrator finds that the July 31, 2018 work injury caused or aggravated the Petitioner's lumbar spine, which continues to be symptomatic.

The Arbitrator notes that Petitioner had no prior back pain and there was no medical evidence provided showing any treatment for his lumbar spine prior to July 31, 2018. Further, Petitioner was able to work full duty in a warehouse picking thousands of boxes per shift that weighed approximately 25-100 pounds per box. The Petitioner had been working for Respondent for approximately 9 months. He was able to do this pain free until July 31, 2018.

On July 31, 2018, the Petitioner felt pain while he was bending and twisting to wrap a pallet, feeling pain into his right leg. An MRI was done shortly after revealing disc pathology at L4-5.

Dr. Miz opined that the Petitioner has a known pathologic disc at L4-5 with bulge towards the right causing foraminal stenosis which is consistent with his clinical picture. Dr. Kusuma also opined that the Petitioner had L4-5 disc degeneration which is symptomatic following a work injury. Dr. Lorenz opined that the work injury of bending and twisting either caused the L4-5 annular tearing or caused that disc to become symptomatic as a result of the work movement.

The only doctor to disagree that the L4-5 findings are related to the work injury of wrapping the pallet was Dr. Kern Singh. However, Dr. Singh testified that the Petitioner did sustain an injury due to the work-related movement, but it was a muscle strain and the L4-5 pathology was not related. Further, Dr. Singh is the only doctor to opine that there was no radiculopathy during his physical examination.

Dr. Miz found positive straight leg raise on the right and diagnosed radiculopathy. Dr. Kusuma noted positive leg raise on the right. Dr. Lorenz examined Petitioner and noted a positive right sided straight leg raise and diagnosed right lower extremity radiculopathy. Dr. Singh is the only doctor to find no radiculopathy on examination. Further, the Arbitrator has reviewed the surveillance video and agrees with both Dr. Lorenz and Dr. Singh that the video and the actions by the Petitioner in the video do not change the findings of the Arbitrator. The Petitioner was restricted to light duty work at one point before the employer forced him to work above his restrictions. The activities in the video are well within the limits of the light duty work restrictions. Although the Petitioner was taken off of work by his physician, that does not mean he is restricted from his activities of daily life. The activities on surveillance do not demonstrate the Petitioner was able to perform the job duties, nor does it show that the Petitioner had nothing wrong with his lumbar spine. The Arbitrator agrees with Dr. Lorenz's opinion that there is nothing observed on the video that is inconsistent with Petitioner's complaints and findings, nor does the video portray Petitioner doing anything beyond his work restrictions. The Petitioner is off work because he is not capable of performing the duties of his job.

The Arbitrator finds that the July 31, 2018 work injury caused or aggravated the Petitioner's lumbar spine condition, which continues to be symptomatic.

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:

Having found that the injury is causally connected, the Arbitrator finds that all of the medical services provided to Petitioner were reasonable and necessary and awards payment of the outstanding medical bills subject to the fee schedule.

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator finds the surgery recommended by Dr. Miz, Dr. Kusuma and Dr. Lorenz lumbar spine is reasonable, necessary, and customary medical treatment. The Arbitrator further orders that Respondent shall authorize and pay for the prospective surgery as well as any and all reasonable incidental care thereto, as well as authorize any and all further treatment reasonable and necessary for the lumbar spine.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner was restricted from work and off from July 31, 2018 through September 11, 2018 and continues to be restricted from work from September 18, 2018 through the date of the hearing December 4, 2019 representing a period of 69 3/7 weeks. Therefore, the Arbitrator awards TTD of 69 3/7 weeks and continuing through MMI pursuant to Section 8(b) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC009735
Case Name	BEAMUS, PAMELA v. CHRYSLER CORP.
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0183
Number of Pages of Decision	21
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	Jason Esmond
Respondent Attorney	Brian Hindman

DATE FILED: 4/21/2021

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	☒	None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA BEAMUS,

Petitioner,

vs. NO: 15 WC 9735

FCA US, LLC,

Respondent.

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 accident, causal connection, medical expenses, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, 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.

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 award of TTD and PPD benefits. The Arbitrator awarded TTD benefits covering February 13, 2015 through February 26, 2015 and

May 13, 2016 through November 30, 2017. The evidence demonstrated that Petitioner was taken off work by Respondent's medical clinic from February 13, 2015 through February 26, 2015; she was returned to work without restriction on February 27, 2015. The Commission finds that the evidence supports an award of TTD for this 14-day period and thus affirms the Arbitrator's award of benefits. The Commission, however, finds that the evidence does not support the Arbitrator's award of TTD benefits for the period of May 13, 2016 through November 30, 2017.

"It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement." *Interstate Scaffolding v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 142 (2010). An employee is considered temporarily totally incapacitated from the time an injury incapacitates the employee until such time as the employee is as far recovered or restored as the permanent character of his or her injury will permit. *Id.*

Petitioner provided conflicting testimony with respect to her time off work as a result of her right hand/wrist injuries. Petitioner testified that after the May 13, 2016 accident, she returned to her regular duties with Respondent. Petitioner also testified that she was off work in May 2016 and she had not returned to work since. During cross-examination, Petitioner stated that she last worked for Respondent on May 13, 2016. The Commission finds no evidence that a physician had taken Petitioner off work on May 13, 2016. Dr. Brian Bear's May 17, 2016 medical record indicated that Petitioner had been off for two days but was now working with restrictions. Dr. Bear allowed Petitioner to return to work with a 15-pound restriction and Petitioner was required to wear a wrist splint while working.

On May 24, 2016, Petitioner's Section 12 examiner, Dr. Jeffrey Coe, recommended work restrictions that included lifting in the light physical demand level and continued use of the right wrist supportive splint while at work. Dr. Bear's September 15, 2016 office visit note indicated that Petitioner was "working full time at regular job." On this date, Dr. Bear recommended surgery on the right wrist and stated that Petitioner would be off work following surgery; he further estimated that Petitioner would reach maximum medical improvement at approximately six months status post surgical intervention.

The evidence demonstrated that Petitioner was incapacitated on the date of surgery – November 16, 2016. Petitioner subsequently underwent therapy for the right wrist at IAM Rehab Episode in Minneapolis, Minnesota from January 10, 2017 through June 7, 2017. Petitioner's treating physician, Dr. David Ian Smith, DO, recommended a functional capacity evaluation (FCE) on June 23, 2017. Dr. Smith testified at his evidence deposition that he had recommended the FCE to help determine if Petitioner had reached maximum medical improvement. However, Petitioner was unable to proceed with the study. Dr. Smith recommended permanent work restrictions that included no repetitive use or overuse of the right wrist and no lifting more than 10 pounds.

Thereafter, Petitioner consulted with two additional physicians for her persistent, chronic right wrist pain. Both Dr. Amy Teresa Moeller [on October 2, 2017] and Dr. Ariel Aila Williams [on December 18, 2017] stated that a further surgery to remove the stabilizer could lead to worse problems and instability.

In consideration of the evidence in its totality, the Commission finds that Petitioner's condition had stabilized and Petitioner had reached maximum medical improvement on June 23, 2017. As of June 23, 2017, Petitioner was as far recovered or restored as the permanent character of her injury permitted and she was no longer entitled to ongoing TTD benefits. The Commission therefore modifies the TTD period in the Arbitrator's Decision and finds that Petitioner is entitled to TTD benefits from November 16, 2016 through June 23, 2017.

The Commission also modifies the Arbitrator's PPD award. The Arbitrator considered the five factors under Section 8.1b of the Act and awarded fifteen-percent (15%) loss of the person as a whole. With respect to the second factor – the occupation of the injured employee, the Arbitrator noted Petitioner's testimony that she was unable to work. However, the Arbitrator considered the surveillance video offered into evidence by Respondent and did not find sufficient evidence for Petitioner's claim of loss of trade. Despite this, the Arbitrator erroneously awarded 15% loss of the person as a whole in PPD benefits for a right hand/wrist injury with no evidence of any loss in trade. The Commission therefore corrects and modifies the Arbitrator's PPD award to 15% loss of use of the right hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed March 27, 2020, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $33,732.37, as provided in Sections 8(a) and 8.2 of the Act and consistent with the medical fee schedule, related to Petitioner's right wrist injury.

IT IS FURTHER ORDERED BY THE COMMISSION that pursuant to Section 8(j) of the Act, Respondent is entitled to a credit of $77,311.34 for medical bills paid under its group plan that are related to the treatment of injuries found compensable by this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $299.23 per week for 33 3/7 weeks, commencing February 13, 2015 through February 26, 2015, and from November 16, 2016 through June 23, 2017, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $269.31 per week for 30.75 weeks, because the injuries sustained caused the fifteen-percent (15%) loss of use of the right hand under Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all other amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including a credit of $13,062.39 in non-occupational indemnity disability benefits paid.

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 $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: **4/21/2021**

/s/ *Thomas J. Tyrrell*

TJT/pm
O: 3/3/21
051

/s/ *Stephen J. Mathis*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0183
NOTICE OF ARBITRATOR DECISION

BEAMUS, PAMELA
Employee/Petitioner

Case# **15WC009735**

FCA US LLC
Employer/Respondent

On 3/27/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0560 WIEDNER & McAULIFFE LTD
BRIAN HINDMAN
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pamela Beamus
Employee/Petitioner

v.

FCA US LLC
Employer/Respondent

Case # **15 WC 9735**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Rockford**, on **July 17, 2019.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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 the date of accident, **January 19, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On these dates, Petitioner did sustain accidents that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the January 19, 2015 injury, Petitioner's average weekly wage was **$448.85.**

On January 19, 2015, Petitioner was **43** years of age, ***single*** with **0** dependent children.

On the date of accident of May 13, 2016, Petitioner was **44** years of age, single, with **0** dependent children.

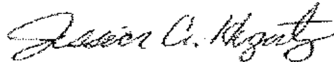
Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

- Respondent shall pay the petitioner temporary total disability benefits of $ **299.23** /week for **135** weeks from **2-13-15 through 2-26-15 and from 5-13-16 through 11-30-17** as provided in Section 8(b) of the Act.
- Respondent is due a credit of $13,062.39 in nonoccupational indemnity disability benefits paid.
- Respondent is due a credit of $77,311.34 in medical bills paid through their group medical plan.
- Respondent is liable for the **$ 33,732.37** in medical bills, as provided in Section 8(a) and 8.2 of the Act and consistent with the medical fee schedule, related to Petitioner's right wrist injury:
- The Respondent shall pay the Petitioner the sum of **$269.31** / week for a period of **75** weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused Petitioner has sustained a **15% loss of a man** 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.



Signature of Arbitrator

3-25-2020
Date

ICArbDec

MAR 27 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA BEAMUS
Employee/Petitioner

v. Case # 15 WC 9735

FCA US LLC.,
Employer/Respondent

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

The parties appeared before the Arbitrator on 7-17-19 for hearing pertaining to three cases: 15 WC 9735, 15 WC 34471, and 16 WC 16894 (Arb. 1, 2, 3). Separate decisions will be issued for each case.

Regarding the case at bar, 15 WC 9735, Respondent disputes accident, causal connection, unpaid medical bills, TTD, and the nature and extent of the alleged injuries (Arb. 1.).

Petitioner (DOB: 8-12-71) was hired by Respondent as an assembler in December 2014 (Tr. 9). Petitioner's duties included attaching front bumpers (aka front fascia) on Dart automobiles (Id. 11). This was a two-person task, with one person on the left and one on the right side of the front bumper. Both individuals would lift the bumper, carry it to the automobile and then "click" the bumper into place (Id.). If the bumper did not "click correctly" Petitioner would "gently tap" the bumper with the palm of her right hand but at times had to use more force with her right palm to secure the bumper (Tr. 12).

Petitioner claims that on 1-19-15 she sustained a work-related injury to her right wrist/hand. On that day she was working on the assembly line placing front bumpers onto Dart automobiles and was on her fourth or fifth vehicle when the bumper did not "click" into place (Tr. 11). She began using more force with her right, dominant hand and "hit" the bumper into place, after which she felt pain "on the pinkie finger side" of her right wrist (Tr. 14). She continued working and moved to the next station which involved attaching taillights to Jeep Compass vehicles (Id.). As she forcefully pushed a taillight into place, she felt excruciating pain along her right pinkie into her right wrist. She notified her team leader, Latisha and supervisor, Eric who then provided her with two Tylenol and instructed her to seek medical treatment while off work over the next couple of days if the swelling did not go down (Tr. 15).

On the afternoon of 1-21-15 Petitioner presented to Old St. Francis Rock Cut Prompt Care in Loves Park ("OSF") where Dr. Asra Khan noted the following:

> Pamela L Beamus is a 43 y.o. female who sustained a right hand injury 3 day(s) ago. Mechanism of injury: was putting in tail lights at work, hit hard with hand, now swollen and painful since the weekend, some numbness in middle finger (Px 2, p. 51).

Petitioner reported no prior problems in her right wrist/hand. On exam, the doctor noted pain, tenderness and swelling mostly along the thenar eminence and mild numbness in the middle finger (Id.).

Right hand/wrist x-rays indicated a small bone spur at the right middle finger distal phalanx base laterally (Px 3, p. 86).

Dr. Khan diagnosed a right hand sprain and instituted a 10 lb. lifting restriction with no repetitive movements for 3 days. The doctor also prescribed pain medications and gave Petitioner a splint (Px 2, p.51).

On 1-21-15, Petitioner presented to Respondent's Plant Medical office ("Plant Medical") with complaints of right wrist pain after an injury on 1-19-15 at 3:30am. (PX 1). Petitioner reported the following history of accident:

> I was working on the line, I started with the Dart placing the front facial clip on and started to receive pain in my right hand. I continued to work and rotate through the line when I got to station 1905 working on the right side placing light fixtures. I was placing the rear light fixture into a Compass and went to push the light fixture in my hand started to receive pain and also began to swell up. I did report to my team leader Lakeisha Williams and Meesha, I also placed ice upon my hand. Eric was not available at the time, when he became available, I did report to him at this time, it was almost time for the shift to be over, so I took 2 Tylenol and finished the shift. I was asked if I wanted to come to medical.

Petitioner presented a light duty note to Respondent's Plant physician, Dr. Wellendorf, who noted:

> [O]btaining the accurate mechanism of injury was difficult with this employee. At first, she told me that she injured her right hand and wrist installing a rear light fixture on a Compass. This is also what her original workers statement reported. But, then after obtaining a detailed history from the employee, it became apparent that she felt that she was having problems before she installed the light fixture on the Compass. At our request in medical, employee filled out another workers statement. Employee had been working at this station for two seeks. Employee states that she was working on 1/19/15 (PX1, p. 4).

Dr. Wellendorf noted Petitioner did not have problems completing the "lengthy workers statements and writing with her dominant affected R hand" (Id.). The doctor also noted the Petitioner was wearing a "padded gloves" at the time of the alleged incident (Id.).

On exam, the doctor noted mild tenderness over the hypothenar region, proximal mid-thumb, and distal 3rd metacarpal -3rd proximal phalanx region and slight sift tissue swelling over proximal mid thumb (Id.). Petitioner was instructed to ice, elevate and wear her splint as directed. Dr. Wellendorf opined that Petitioner's alleged work injury was a "no trauma incident" (Id.).

Petitioner testified the work restrictions provided to Respondent were not accommodated as she was performing essentially the same tasks as before her injury (Tr. 16).

On 1-28-15 Petitioner underwent a right upper extremity EMG that was interpreted as normal with no evidence of active denervation (Px 3, p. 136).

On 1-28-15 Plant Medical noted Petitioner reported increased pain with twisting and pushing motions (Px. 1). She was wearing a splint and taking Meloxicam (Px 1).

On 2-4-15 Petitioner reported to Plant Medical that her right wrist felt better (Id.). Petitioner stated that she was doing her regular job with no problems and did not need restrictions (Id.). Petitioner also stated she was no longer taking medication, had no swelling, and only had slight residual discomfort (Id.). RN Rios noted that per a conversation with Eric Bertram, Petitioner's supervisor, Petitioner had been working full duty with no complaints (Id.).

On 2-12-15 Petitioner presented to Plant Medical where E Kastler, RN, noted Petitioner was wearing a support splint. Petitioner reported that twisting her wrist in a certain way caused pain and complained of numbness and tingling in the right middle finger and thumb along with problems gripping secondary to wrist pain. Petitioner presented a note from Dr. Martens at OSF Medical dated 2-10-15 in which Dr. Martens asked Respondent to honor Petitioner's light duty restrictions as Petitioner had reported to Dr. Martens that the previous light duty restrictions had not been honored (Px 1). Dr. Martens stated that Petitioner was restricted from lifting more than 10 lbs. or engaging in repetitive movements for 14 days. In addition, Petitioner was to wear a splint at work until further notice (Id.). Petitioner reported that due to seniority she was bumped to a different job, which she described as light and nonstrenuous. She did not believe the restrictions provided from Dr. Martens would impact her new job but said her doctor wanted them in place anyway (Id.).

On 2-27-15, Petitioner presented to Plant Medical after being totally disabled for her right wrist and hand injury from 2-13-15 to 2-26-15 (Id.). She was authorized to return to work on 2-27-15 with no restrictions (Id.).

On 2-28-15, a right wrist MRI performed at OSF Rock Cut Crossing noted:

1. Significant medial subluxation and possible rupture of the extensor carpi ulnaris (ECU);
2. Carpal tunnel unremarkable. Median and ulnar nerves grossly unremarkable;
3. No significant bone marrow edema to suggest acute fracture noted;
4. Early DJD at fourth metacarpal joint suspected due to mild edema (Px. 3, p. 99).

On 3-14-15, Petitioner presented to the emergency room at Swedish American after falling about 8 feet down some stairs (Px 4; Rx 19). She described pain in the dorsum of the right hand, left lateral ankle, decreased range of motion, and swelling. X-rays of the right hand were normal and Petitioner was diagnosed with a contusion to the upper extremity and an ankle sprain (Id.).

On 3-19-15 Petitioner treatment at OrthoIllinois where she reported a history of right wrist pain after hitting the front bumper with her hand while she was working on a car (Px. 5). She was diagnosed with subluxation of the left extensor carpi ulnaris tendon. She was recommended medication as well as an EMG to rule out peripheral nerve compression (Id.).

On 4-2-15 Petitioner underwent a right upper extremity EMG study at Ortho Illinois to rule out peripheral nerve compression (PX 5). The study showed cubital tunnel syndrome. Dr. Bear noted in his encounter records on 4-14-15 that the study showed mild right ulnar nerve conduction delay across the elbow, which was demyelinating but not axonal with no FDIM denervation. No evidence of carpal tunnel syndrome or other neuropathy was found (*Id.*).

On 4-13-15, Petitioner presented to OSF Rock Cut Crossing with a history of right hand pain and swelling after punching a wall (Id., p. 106). She was diagnosed with a middle phalangeal spiral fracture of her right ring finger (Id.).

On 6-8-15 Petitioner presented to OrthoIllinois for an occupational therapy evaluation regarding her (non-work) fracture in the middle phalanx of her right ring finger that occurred on 4-13-15 (Px 5, p. 308). The Arbitrator notes Petitioner reported to the therapist that she injured her finger at work when she "caught her finger at work on a hand drill" (Id.). Her main complaint concerned intermittent throbbing in the ring finger and numbness in the tip of the finger. She also complained of right wrist pain and hand numbness that lasts the entire night. She had been working at her regular job. She was taking Norco as needed. A wrist splint was provided to be worn at work. Therapy was not ordered (Id., p. 306).

On 6-9-15 Dr. Bear at OrthoIllinois signed a return to work order with the requirement Petitioner wear cock-up wrist splint at work due to right wrist pain (*Id.*). Another note released Petitioner to work without restrictions related to closed fracture of phalanx of finger (*Id.*).

On 8-7-15 Petitioner presented to Swedish American ER (PX 4). She reportedly noticed a small bump in her right inguinal area after shaving one week ago. She thought that it was a skin problem but started to gradually get larger. Petitioner said that the pain worsens with lifting and moving activity. Petitioner said that it started as pimple one week ago but got worse. A CT exam revealed a right inguinal hernia (*Id.*).

On 8-20-15 Petitioner presented to Plant Medical for a recheck of the right ring finger and right wrist (RX 1). She brought paperwork from Dr. Bear releasing her to return to work with the use of a splint on her right ring finger and right wrist. Dr. Bear noted a diagnosis of wrist pain and mallet deformity. Petitioner stated she was considering right wrist surgery. Petitioner was also seen for a reinstatement exam related to a hernia. She reportedly was scheduled for hernia surgery on 9-9-15 (Id.). Petitioner was reinstated to work through the surgery date (*Id.*).

Petitioner participated in physical therapy for her right wrist between 11-19-15 and 2-8-16 (Id.).

In February of 2016, Petitioner and Dr. Bear discussed the possibility of surgery to address her wrist injury. Petitioner did not want to proceed because, according to her testimony, she was concerned about her ability to heal from surgery and her ability to financially support herself (Tr. 24). Petitioner was released to work with 10-pound weight restrictions and instructions to wear a brace (*Id.*). Petitioner testified that she went back to her regular job for and then a few days later was moved to a test-driving role, which she performed for a few weeks (Tr. 25).

On 2-15-16 a repeat right wrist MRI was performed at OrthoIllinois to assess for a TFCC tear. A history of pain with repetitive movement and lifting was noted and a clicking in the wrist since 1-18-15 was noted. The MRI indicated:

1. Mild ECU tendinosis. No microtear;
2. Mild dorsal capsular swelling felt related to repetitive microtrauma. No intrinsic ligament tear. TFC and peripheral attachments intact;
3. Tiny 3.5 mm ganglion dorsal to the scapholunate interval.(Id.).

On 2-25-16 Petitioner was seen for an Independent Medical Examination ("IME") with Dr. Stephen Weiss (Rx. 5). Dr. Weiss diagnosed cubital tunnel syndrome and extensor carpi ulnaris, unrelated to her work injury. Dr. Weiss did not feel that Petitioner's work activities were forceful enough to cause the injuries (Id.).

On 2-25-16 an injection to Petitioner's right wrist was administered by Dr. Brian Bear at Ortho Illinois (Px. 5).

On 2-25-16 Petitioner was seen at Plant Medical for reinstatement at which time she presented light duty restrictions. Petitioner reported again to Plant Medical on 3-9-16. Petitioner testified she was told that if she was still on restrictions, she was not needed.

Plant Medical records indicate that Petitioner's restrictions regarding her hernia surgery (15 WC 34471) were lifted as of 3-21-16 (Px. 1). She remained restricted regarding her right wrist (Id.).

On 2-29-16 MRI ruled out the cervical spine as the cause of her ongoing right hand and wrist symptoms (Px 5, p. 328).

Petitioner returned to work around 3-31-16 with use of the wrist splint.

Petitioner alleges she aggravated her right wrist injury (16 WC 16894) on 5-13-16 from continuously lifting a box, similar in weight to a gallon of milk in the performance of her work duties. She testified she repeatedly lifted and placed the box in every automobile, after which she clamped and secured the box to the car (Tr. 26). She was excused from work and sought treatment at the emergency room (Id., 28). She returned to her regular job the next day (Id.). An Employer's First Report of Injury Form noted that on 5-13-16, Petitioner was connecting a hose to a water line when her hand slipped, striking it against a part in the car. She suffered a contusion and strain to her right wrist and hand (Rx. 14).

Petitioner testified that Dr. Martin took her off work in May of 2016 and she has not returned since (Id., 29).

On 5-17-16 Petitioner was seen by Dr. Bear at Ortho Illinois with complaints of right wrist pain and numbness/tingling in her hand. She described a "new injury to the right wrist on Friday night while at work" (Px. 5). Petitioner was again placed on restrictions. Dr. Bear recommended another MRI to rule out an occult fracture based on her history and exam findings. A 15 lb. weight restriction and instructions to wear a wrist splint while working were noted.

On 5-24-16, at her attorney's request, Petitioner was seen by Dr. Jeffrey Coe for an Independent Medical Examination. Petitioner reported to the doctor that her job involved pounding fascia in place with the palm of her right hand as well as installing tail lights. Dr. Coe opined that a causal relationship existed between Petitioner's work activities and her right hand and wrist symptoms. He noted her symptoms were consistent with ECU tendinitis and that additional treatment was necessary. He opined Petitioner should be restricted to light duty work with continued use of the right wrist splint while working (Px. 10).

On 5-26-16 Petitioner presented to Dr. Bear for a recheck of her right wrist pain and hand numbness. Her main complaint was pain at the ulnar aspect of her wrist with occasional swelling along with numbness/tingling in the entire hand, worse at night (Px 5.). Dr. Bear reviewed an updated right wrist MRI from 5-23-16 noting the ECU tendinosis had progressed slightly while a flat 5.3 mm ganglion cyst dorsal to the scapholunate interval was similar when compared to the previous exam (Id.). Additional conservative care was recommended. Petitioner did not return to work for Respondent after May of 2016.

On 6-19-16, Petitioner was seen for neck and back pain after a tree branch fell onto the trunk of the car she was sitting in. Petitioner underwent physical therapy for her left arm and neck from 6-28-16 through 9-7-16 (Px. 7). She began treatment with Dr. David Ian Smith on 9-12-16 due to left sided neck and arm pain from that accident (Px. 12).

On 11-16-2016 Petitioner underwent surgery performed by Dr. Bear at OrthoIllinois Surgery center. The preoperative diagnosis noted: right wrist occult dorsal carpal ganglion cyst, right wrist extensor carpal ulnaris subluxation, and right wrist possible triangular fibrocartilage complex injury. The procedure included right wrist arthroscopy, debridement, arthroscopic ganglion cyst removal, open extensor carpal ulnaris tenosynovectomy, stabilization of subluxation extensor carpi ulnaris tendon, and wrist block. The Postoperative diagnosis noted there was no evidence of triangular fibrocartilage complex tear. No complications were noted and Petitioner was discharged home (Px. 5).

On 11-30-16 Petitioner was seen postoperatively and placed in a long-arm cast (Id.).

Petitioner testified she moved to Minneapolis on November of 2016 (Tr. 59).

On 12-20-16 Petitioner began treating with David Ian Smith, DO, at Fairview Maple Grove Medical Center in Minneapolis for her right wrist. Dr. Smith noted he had instructions from Petitioners surgeon regarding

aftercare for her wrist (Px 12, p. 825). The doctor removed her long-arm cast, instituting a short-arm cast (Id.).

On 12-24-16, Petitioner complained that the cast was too tight, causing numbness and tingling. The cast was removed and her arm was wrapped (Px. 8).

On 1-3-17, Petitioner was referred to occupational therapy (Px. 12).

On 1-4-17, Petitioner was involved in a motor vehicle accident while riding in the passenger seat when she braced herself with her right arm, striking it on the dashboard. X-rays revealed no fracture or dislocation at that time (Rx. 4).

On 1-10-17 Petitioner began physical therapy for her right hand at the Institute for Athletic Medicine (Px. 7).

On 1-13-17, Dr. Smith noted that Petitioner had injured her surgically recovering right wrist in a motor vehicle accident.

On 1-23-17 a repeat MRI of Petitioner's right wrist was performed which demonstrated a 1x 2.2. x 1.9 cm stabilizer within the subcutaneous soft tissue in the dorsal wrist. Diffuse osteopenia was appreciated secondary to disuse vs. chronic. Ulnar styloid showed bony edema (Px 12, p. 846).

Petitioner continued in physical therapy in Minneapolis through 2-17-17 (Px. 7).

Petitioner was referred to Dr. Amy Moeller for evaluation regarding the impact of the motor vehicle accident on Petitioner's implanted stabilization device. Dr. Moeller examined Petitioner on 3-20-17. After review of the 1-23-17 MRI, Dr. Moeller opined that there was not an acute etiology for her persistent pain noting that pain was expected 4 months out from her surgery, but that her symptoms were likely exacerbated by the car accident (Px. 12).

Petitioner resumed physical therapy at Fairview Maple Grove Medical Center and continued in therapy from through 6-8-17. On 4-27-17, Dr. Smith noted that physical therapy was going well, and Petitioner had regained some motion and strength in her right hand however, she still had difficulty gripping most things without pain and could not lift more than 10 lbs. without a setback (Id.).

On 6-23-17, Dr. Smith noted Petitioner's complaints of continued difficulty with her grip and with pain on the ulnar side of her wrist. He suggested a Functional Capacity Evaluation (Id.). The FCE was not approved and therefore not performed. Petitioner continued to complain of numbness in the hand. An EMG was recommended to rule out nerve entrapment. The EMG of 8-21-17 was normal (Id.).

Due to ongoing symptoms, Petitioner wanted to consider taking the stabilizer out of her arm. On 8-21-17, Dr. Smith referred Petitioner back to Dr. Moeller for surgical evaluation and on 10-2-17 Dr. Moeller noted Petitioner's complaints included difficulty opening jars and carrying grocery bags. Dr. Moeller explained that removing the stabilizer could cause more problems or lead to instability (Id.). Petitioner was seen by Dr. Ariel Williams for another opinion regarding the stabilizer and Dr. Williams agreed that removal of the stabilizer would almost certainly result in recurrence of Petitioner's ECU instability (Id.).

Petitioner continued to treat with Dr. Smith and on 1-25-18, Dr. Smith opined that Petitioner can work, but couldn't perform a job requiring repetitive use of her right wrist, frequently carrying objects exceeding 5-10 lbs., or tasks that require her to hold objects out at length (Id.). That opinion was reiterated by Dr. Smith on 11-7-18 in a letter articulating that Petitioner's condition and limitations are now likely permanent (Px.

13). Petitioner testified she provided her restrictions to Respondent and was informed they do not have work for her within her restrictions.

Dr. David Ian Smith was deposed on 2-1-19 (Px. 14). Dr. Smith testified that Petitioner should not lift more than 10 pounds on a repetitive basis. He did not feel that she could return to work for Respondent, based on her description of her position. He offered the opinion that her restrictions are now permanent. Dr. Smith testified that he did not feel the 1-3-17 motor vehicle accident materially changed the condition of Petitioner's wrist. He noted the MRI performed after the motor vehicle accident demonstrated a chronic appearance of the tendon, noting stenosis and a split tear that represent more of a chronic injury that was likely present before the motor vehicle accident. He noted the bony edema that was caused by the accident as well that did not correlate with a new injury to the already damaged tendon.

Dr. Stephen Weiss saw Petitioner for a second Independent Medical Examination on 4-30-19 (Rx. 6). At that time, Dr. Weiss was asked whether various intervening accidents, including the fall down stairs on 4-14-15, punching a wall on 4-13-15, falling down on 10-5-15, the 6-19-16 tree falling onto her car, or the 1-3-17 motor vehicle accident impacted her treatment or diagnoses. He indicated that Petitioner denied any permanent change in her status following those accidents and that "the treatment records I reviewed do not contradict this" (Rx. 6). Dr. Weiss continued to opine that Petitioner's work activities were not sufficiently forceful to cause her tendinitis or tendon subluxation. Dr. Weiss also opined that Petitioner could return to regular work activities (Id.).

Petitioner remains in physical therapy and is taking Gabapentin, Flexeril, and Percocet (Tr. 36-37).

Respondent submitted surveillance of Petitioner performing grocery shopping for approximately 10 minutes on 3-8-19 (Rx. 10). Petitioner stated that she worked delivering groceries at the end of 2017. Petitioner testified that she would decline to take orders that involved heavy lifting (Tr. 37). She stated that after carrying a gallon of milk or two, she realized that this irritated her injury, which made it hard for her to perform this job (*Id.*). Petitioner testified that she would work seven to eight hours performing this job per week (Tr. 38). Later in the hearing, Petitioner testified she last delivered groceries a few days prior to trial (Tr. 60).

In describing her current symptoms, Petitioner claimed that she is not able to stick a key in a door, has difficulties with daily cleansing of her own body, trouble with zippers and buttons, and difficulty writing with her right hand (Tr. 39). Petitioner stated that she has not looked for other work because she is not able to do much and in today's world repetitive motion is included in everything (Tr. 40). Finally, she stated that since May of 2016 she has not received any work comp benefits (Tr. 41).

Testimony of Eric Bertram

Respondent called Eric Bertram who testified that on the accident date he was a production supervisor for Group 11 which handled assembly of "TCF, trim, chassis and final" (Trans. 65). His job duties included supervising 60 people in 6 teams of 10, one of whom was Petitioner (Id.).

Mr. Bertram described the task of attaching the front bumper (aka fascia) noting that a vehicle is carried on a monorail system to the various plant stations (Trans. 68). An employee at any given station then has approximately 48-50 seconds to perform a series of activities. Regarding Petitioner's front bumper station, Mr. Bertram testified that two employees unwrap a canvas coated bumper which they carry back to the car and secure to the car with a series of "pushpins". The pushpins are hammered into place using a rubber mallet (Id.). The task is performed 120 times per 2 hour rotation. Mr. Bertram acknowledged that employees "could have" used their hand to force the pushpins into place although that would have gone against Respondent's standard procedure (Id.). He agreed workers could have been using their hands to do the fascia job and he had not reprimanded anyone for doing so. Mr. Bertram also agreed that Petitioner was rotating between 3 positions, 2 hour shifts each in January of 2015. So, over a 10 hour shift, she would

have repeated 2 of the positions. Mr. Bertram testified that he was consistently successful in finding accommodations for injured employees because of the wide array of stations at the Respondent's plant (Tr. 7).

CONCLUSIONS OF LAW

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

Petitioner testified to the onset of pain to the dorsal aspect of her right wrist when she hit a bumper with the palm of her hand. Petitioner testified that she felt pain but continued to the next shift in her rotation, installing taillights onto a different vehicle. Petitioner testified that while pushing in a taillight, the pain in her wrist became excruciating and she reported her injury. The Arbitrator notes that Petitioner performed the bumper assembly job for a relatively short period of time, however, this duty required her to strike her hand repeatedly to car bumpers in order to fulfill this task. Petitioner worked in this capacity for 2-4 hours a day, assembling approximately 120 vehicles per 2 hour shift, according to Respondent's witness. Petitioner's testimony regarding the accident is corroborated in records from Respondent's Plant Medical department and the treating medical records from OSF Rock Cut Crossing, Ortho Illinois, and in the report issued by Respondent's Independent Medical Examiner (Px. 1, 2, 5, 10; Rx 6).

Based on a preponderance of the credible evidence, the Arbitrator finds that Petitioner sustained her burden regarding this issue.

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

The Arbitrator relies upon the well-established rules set forth by the Illinois Supreme Court that "the fact that an employee may have suffered from a preexisting condition will not preclude an award if the condition was aggravated or accelerated by the employment. The employee need not prove employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor in the resulting injury." Williams v. Industrial Com., 85 Ill. 2d 117, 122 (1981).

Petitioner's treatment records support a causal relationship between her current condition of ill-being as it related to her right hand/wrist. Petitioner immediately began treating for her right wrist after the 1-19-15 injury. A right wrist MRI on 2-28-15 revealed significant subluxation of the extensor carpi ulnaris. It was also suspected that the ECU sub-sheath may be ruptured (Px. 3). Petitioner began treatment at Ortho Illinois on 3-19-15 where she was diagnosed with subluxation of the left extensor carpi ulnaris tendon (Px. 5). Surgery was discussed as a possibility on 8-20-15 (Id.). Over the next several months, Petitioner treated conservatively for her continued right wrist pain. She underwent an EMG and cervical spine MRI to rule out radicular or neuropathic causes for her symptoms. A repeat right wrist MRI, performed on 2-15-16, demonstrating mild ECU tendinosis and mild dorsal capsular swelling possibly related to repetitive microtrauma (Px. 5).

Respondent's examining physician, Dr. Weiss, agreed with the diagnosis of extensor carpi ulnaris, but opined that Petitioner's work activities were not forceful enough to cause the condition (Rx. 6). Dr. Coe opined that there was a causal relationship between Petitioner's work activities and her right hand and wrist symptoms, noting her symptoms were consistent with ECU tendinitis and that additional treatment was necessary (Px. 10).

On 11-16-16, Dr Bear performed surgery at Ortho Illinois consisting of: 1. Right wrist arthroscopy, debridement, and ganglion cyst removal; 2. Open extensor carpi ulnaris tenosynovectomy; 3. Stabilization of subluxation in the extensor carpi ulnaris tendon was performed (Px. 5).

Petitioner testified she moved to Minneapolis in November of 2016 (Trans. 59).

On 1-4-17 Petitioner was involved in a car accident (Tr. 32). Petitioner was seated in the front passenger seat when her car rear-ended the car in front of them (Tr. 33). Petitioner was thrown forward and her right arm struck the dashboard (*Id.*). Petitioner described feeling pain in the same location she had pain from before the motor vehicle accident (*Id.*). Petitioner asserted that she had gotten her cast off that day, but she wore a brace that she had previously received from Chrysler (Tr. 50).

Petitioner underwent an MRI after auto accident due to concerns that she had re-injured the extensor carpi ulnaris tendon or the stabilization device.

After review of the 1-23-17 MRI, Dr. Moeller opined that there was not an acute etiology for her persistent pain. Dr. Smith noted his opinion that the MRI performed after the motor vehicle accident demonstrated a chronic appearance of the tendon, noting stenosis and a split tear that represent more of a chronic injury that was likely present before the motor vehicle accident. He noted the bony edema that was caused by the accident as well that did not correlate with a new injury to the already damaged tendon. (Px. 14).

Petitioner testified her right wrist symptoms have not resolved since her surgery. She underwent multiple rounds of physical therapy without symptomatic improvement. (Px. 7). Petitioner sought multiple opinions regarding removal of the stabilization device installed on November 16, 2016. All agree that she should refrain from having the device removed as removal would likely result in recurrence of ECU instability. (Px. 12). Petitioner has continued treatment with Dr. Smith who has offered the opinion that she now has permanent restrictions regarding her right wrist. (Px. 14).

The Arbitrator recognizes that Petitioner has sustained *multiple* accidents since she experienced this initial injury on January 19, 2015. The most notable being the January 4, 2017 motor vehicle accident and additional accidents sustained by Petitioner that could potentially have resulted in a right wrist injury. It should be noted that Petitioner's February 28, 2015 MRI noted significant subluxation of the extensor carpi ulnaris, which was prior to any of the subsequent accidents. (Px. 2). Further, Respondent did not offer an opinion that any of the subsequent accidents or injuries substantially changed the course of Petitioner's right wrist injury. When Dr. Weiss, Respondent's IME physician, was asked whether the various intervening accidents, including: a fall down stairs on March 14, 2015, punching a wall on Apri 13, 2015, falling down on October 5, 2015, a tree falling onto her car, or the January 4, 2017 motor vehicle accident impacted her treatment or diagnoses, he indicated that Petitioner denied any permanent change in her status following those accidents and that "the treatment records I reviewed do not contradict this." (Rx. 6). As such, the Arbitrator does not find that any of the subsequent accidents in which Petitioner were involved were intervening accidents that broke the chain of causation.

Petitioner sustained an injury to her right wrist on January 19, 2015. An MRI performed only 6 weeks later revealed significant subluxation of the extensor carpi ulnaris. Petitioner initially treated conservatively, but underwent surgery on November 16, 2016 for the condition noted on the February 28, 2015 MRI. She has seen multiple surgeons to discuss removal of the implanted stabilization device due to ongoing symptoms, despite the surgery. Dr. Smith opined that Petitioner's current symptoms remain causally related to the surgery performed in November 2016. Based on a preponderance of the credible evidence the Arbitrator finds Petitioner's current condition of ill-being is causally related to her January 19, 2015 injury.

Regarding Petitioner's companion case 15 WC 16894, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to that accident. The medical records subsequent to that accident indicate that Petitioner sustained a contusion at that time. Her symptoms did not materially change after May 13, 2016. She was working with restrictions prior to May 13, 2016, had been in physical therapy only a month prior, and did not experience significantly increased symptoms thereafter. Therefore,

the Arbitrator finds that Petitioner's May 13, 2016 injury was a temporary exacerbation of her January 19, 2015 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?

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary for the injuries she sustained as a result of this accident.

Respondent is due a credit of $77,311.34 in medical bills paid through their group medical plan.

Petitioner's Exhibit 11 contains $90,281.95 in group benefits paid.

Respondent is liable for the following medical bills pursuant to the fee schedule regarding Petitioner's right wrist:

OSF Medical Group (visits on 1/27/15; 2/10/15; 2/26/15; 11/11/15)	$291.00
Ortho Illinois (visits from 3/19/15 – 9/15/16, including 11/16/16 surgery)	$6,848.77
Ortho IL Surgery Center (11/16/16 surgery)	$24,612.50
OSF Medical Center (1/21/15; 1/28/15; 2/28/15; 4/13/15)	$1,980.10

K. What temporary benefits are in dispute?

Petitioner was initially taken off work for her right wrist injury on 2-13-15 before returning to work with use of a brace on 2-27-15. She continued to work thereafter until 8-6-15 when she was taken off-work due to an alleged work-related hernia which the Arbitrator found non-compensable (15 WC 34471).

On 5-13-16 Petitioner sustained a work-related contusion to her right wrist (16 WC 16894). Dr. Bear and again placed on restrictions regarding her right wrist. Surgery was performed on her right wrist on 11-16-16 and she was placed in long-arm cast on 11-30-16. Thereafter, Petitioner began treatment with Dr. Smith due to continued difficulty with grip and pain on the ulnar side of the right wrist. Petitioner underwent multiple rounds of physical therapy and has had various consultations regarding additional surgery to potentially remove the stabilization device implanted.

Petitioner also admitted to having a job with a grocery service. Surveillance footage from 5-8-19 shows Petitioner using her right hand to pick up bags, resting the ulnar border of her right hand on the cart handle, and bracing her body with her right hand while climbing over a snow pile to get into her car.

Petitioner testified she began working as an independent contractor shopping for groceries at the end of November 2017.

Based on a preponderance of the credible evidence contained in the record, the Arbitrator orders Respondent shall pay the petitioner temporary total disability benefits of $ 299.23 /week for 135 weeks, from 2-13-15 through 2-26-15 and from 5-13-16 through 11-30-17 as provided in Section 8(b) of the Act.

The Arbitrator notes that Respondent is due a credit of $13,062.39 in nonoccupational indemnity disability benefits paid.

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

The Arbitrator adopts the findings of fact stated above and incorporates them herein by this reference. In assessing the nature and extent of Petitioner's injury, the Arbitrator must consider the following five factors:

1) *An impairment report* prepared by a physician using the most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment." No impairment rating was offered by either party.

2) *The occupation of the injured employee:* Petitioner was working as a full time auto assembler on the accident date. Her duties included attaching front bumpers and rear tail lights on automobiles. Petitioner's osteopath, David Ian Smith, opined that Petitioner can work, but that she cannot perform a job requiring repetitive use of her right wrist, frequently carrying objects exceeding 5-10 lbs., or tasks that require her to hold objects out at length. Although Petitioner testified that she cannot work, surveillance footage shows otherwise. The surveillance footage showed petitioner rest the ulnar border of her right hand on a shopping cart handle, use her right hand to pick up bags, and brace her body with her right hand while climbing over a snow pile to get into her car (RX 10). Although Petitioner claims a loss of trade, the Arbitrator does not find sufficient evidence in support.

3) *The age of the employee at the time of the injury:* Petitioner was 43 years old at the time of her injuries. She has many years left in her life to live with her wrist injury and many years left in her work life. The Arbitrator assigns greater weight to this factor.

4) *The employee's future earning capacity*: Based on the evidence this Arbitrator finds insufficient evidence in support of this factor.

5) *Evidence of disability corroborated by the treating medical records*: Petitioner underwent surgery in on 11-16-16 consisting of right wrist arthroscopy, debridement, ganglion cyst removal, open extensor carpi ulnaris tenosynovectomy, as well as stabilization of subluxation extensor carpi ulnaris tendon. Multiple evaluations have been conducted to assess removal of the implanted stabilization device due to her ongoing complaints. It has been opined that removal would worsen Petitioner's current condition. Petitioner testified to ongoing pain in her right wrist, difficulty lifting a gallon of milk, the inability to open jars, difficulty buttoning and zipping clothes with her right hand and difficulty holding a pen to write for more than 5 minutes. Petitioner has remained on medication and modified her activities. The Arbitrator places greater weight on this factor.

Petitioner testified she moved to Minneapolis in November of 2016. Petitioner has a GED and attended Rock Valley College for one year where she became a Certified Nursing Assistant (Trans. 61).

Based on a preponderance of the credible evidence presented the Arbitrator finds Petitioner has sustained a 15% loss of a man as a whole under Section 8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC034471
Case Name	BEAMUS, PAMELA v. CHRYSLER CORP ASSEMBLY PLANT
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0184
Number of Pages of Decision	9
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	Jason Esmond
Respondent Attorney	Brian Hindman

DATE FILED: 4/21/2021

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA BEAMUS,

Petitioner,

vs. NO: 15 WC 34471

FCA US, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 27, 2020 is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) of the Act is applicable only when "the Commission shall have rendered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: **4/21/2021** /s/ *Thomas J. Tyrrell*

TJT/pm

O: 3/3/21
051

/s/ *Stephen J. Mathis*

____

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0184
NOTICE OF ARBITRATOR DECISION

BEAMUS, PAMELA
Employee/Petitioner

Case# **15WC034471**

FCA US LLC
Employer/Respondent

On 3/27/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0560 WIEDNER & McAULIFFE LTD
BRIAN HINDMAN
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pamela Beamus
Employee/Petitioner
v.
FCA US LLC
Employer/Respondent

Case # **15 WC 34471**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Rockford**, on **July 17, 2019.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

C. [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 the date of accident, **August 6, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner's average weekly wage was **$612.50.**

On August 6, 2015, Petitioner was **43** years of age, ***single*** with **0** dependent children.

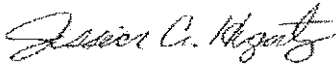
Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

Because Petitioner failed to sustain her burden with respect to accident, all benefits are denied.

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

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



Signature of Arbitrator

3-25-2020
Date

ICArbDec

MAR 27 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA BEAMUS
Employee/Petitioner

v. Case # 15 WC 34471

FCA US LLC.,
Employer/Respondent

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

The parties appeared on 7-17-19 for hearing pertaining to three cases: 15 WC 0735, 15 WC 34471, and 16 WC 16894 (Arb. 1, 2, 3). Separate decisions will be issued for each case.

Regarding the case at bar, 15 WC 34471, Respondent disputes accident, causal connection, unpaid medical bills, TTD, and the nature and extent of the alleged injuries (Arb. 1.).

The week before her alleged work-related injury, Petitioner was seen at OSF Rock Cut regarding tenderness in her right groin for the past 2 days. She was diagnosed with cellulitis and an abscess (Px. 2).

Petitioner alleges that on 8-6-15 she lifted a jug of coolant off a shelf, turned and leaned over the open hood of a car when she felt sharp lower abdominal pain (Tr. 20-21). Petitioner testified she stepped off the line and notified her team leader that she must leave work (Id.).

On 8-7-15, Petitioner was seen at Swedish American Hospital ER where she reported a history of noticing a small bump to her right inguinal area after shaving one week ago (Px. 4). The bump had started to get larger and was reportedly worsened with lifting and moving activity. She reported experiencing different pain to her right lower quadrant the day before. A CT scan revealed a right femoral hernia (Id.).

Petitioner was seen at Plant Medical on 8-20-15 where she report "sneezing" at work one day, causing a groin hernia. It was noted that she was scheduled for surgery on September 9, 2015 relative to a right femoral hernia (Px. 1).

At her preoperative visit on 9-2-15, Petitioner reported that she had stopped working at her job because her work was aggravating her right lower quadrant abdominal pain and causing more swelling due to the heavy lifting (Px. 4). Petitioner underwent the hernia repair on 9-9-15 (Id.). The postoperative diagnosis was a right femoral hernia and an umbilical hernia (Id.). On 10-5-15 Petitioner presented to Swedish American due to post-surgical pain after her dog knocked her over and she fell onto her right side (Id.). A CT scan performed on December 7, 2015 noted no recurrent hernia (Id.).

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to sustain her burden with respect to this issue.

The Arbitrator relies on the reported medical history noting that nearly four years from the date of this alleged work injury, Petitioner's story does not match with what is shown in medical records.

The Arbitrator finds that Petitioner did not meet her burden of proof to establish her hernia arose out of the course of her employment.

Although it is not necessary to consider the issue of causal connection, the Arbitrator notes Petitioner presented no medical causation opinion.

All other issues are moot with respect to this case. Benefits are denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC016894
Case Name	BEAMUS, PAMELA v. FCA US LLC
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0185
Number of Pages of Decision	15
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	Jason Esmond
Respondent Attorney	Brian Hindman

DATE FILED: 4/21/2021

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF WINNEBAGO	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA BEAMUS,

Petitioner,

vs. NO: 16 WC 16894

FCA US, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 27, 2020 is hereby affirmed and adopted.

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

DATED: 4/21/2021

/s/ Thomas J. Tyrrell

TJT/pm
O: 3/3/21
051

/s/ *Stephen J. Mathis*

____

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0185
NOTICE OF ARBITRATOR DECISION

BEAMUS, PAMELA
Employee/Petitioner

Case# **16WC016894**

FCA US LLC
Employer/Respondent

On 3/27/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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

0560 WIEDNER & McAULIFFE LTD
BRIAN HINDMAN
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pamela Beamus
Employee/Petitioner
v.
FCA US LLC
Employer/Respondent

Case # **16 WC 16894**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Rockford**, on **July 17, 2019.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 the date of accident, **May 13, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

Timely notice of these accidents ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to her accident on May 13, 2016. Petitioner's May 13, 2016 injury was a temporary exacerbation of her January 19, 2015 injury (15 WC 0735).

In the year preceding the May 13, 2016 injury, Petitioner's average weekly wage was **$612.50.**

On May 13, 2016, Petitioner was **44** years of age, ***single*** with **0** dependent children.

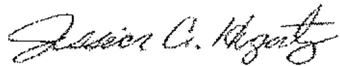
Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

The Arbitrator finds that Petitioner's accident on May 13, 2016 caused a temporary exacerbation of her January 19, 2015 right wrist/hand injury and is not related to her current condition (See Arbitrator's Decision & Addendum 15 WC 9735).

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

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

3-25-2020
Date

ICArbDec

MAR 2 7 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA BEAMUS
Employee/Petitioner

v. Case # 16 WC 16894

FCA US LLC.,
Employer/Respondent

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

The parties appeared on 7-17-19 for hearing pertaining to three cases: 15 WC 9735, 15 WC 34471, and 16 WC 16894 (Arb. 1, 2, 3). Separate decisions will be issued for each case.

The Arbitrator found that Petitioner sustained her burden of proof with respect to her initial work-related wrist injury on 1-19-15 (See Arbitrator's decision and addendum, 15 WC 9735).

Regarding the case at bar, 16 WC 16894, Respondent disputes accident, causal connection, unpaid medical bills, TTD, and the nature and extent of the alleged injuries (Arb. 3.).

Petitioner (DOB: 8-12-71) was hired by Respondent as an assembler in December 2014 (Tr. 9). Petitioner's duties included attaching front bumpers (aka front fascia) on Dart automobiles (Id. 11). This was a two-person task, with one person on the left and one on the right side of the front bumper. Both individuals would lift the bumper, carry it to the automobile and then "click" the bumper into place (Id.). If the bumper did not "click correctly" Petitioner would "gently tap" the bumper with the palm of her right hand but at times had to use more force with her right palm to secure the bumper (Tr. 12).

15 WC 9735
Prior Wrist Injury

Petitioner testified that on 1-19-15 she sustained a work-related injury to her right wrist/hand. On that day she was working on the assembly line placing front bumpers onto Dart automobiles and was on her fourth or fifth vehicle when the bumper did not "click" into place (Tr. 11). She began using more force with her right, dominant hand and "hit" the bumper into place, after which she felt pain "on the pinkie finger side" of her right wrist (Tr. 14). She continued working and moved to the next station which involved attaching taillights to Jeep Compass vehicles (Id.). As she forcefully pushed a taillight into place, she felt excruciating pain along her right pinkie into her right wrist. She notified her team leader, Latisha and supervisor, Eric who then provided her with two Tylenol and instructed her to seek medical treatment while off work over the next couple of days if the swelling did not go down (Tr. 15).

On the afternoon of 1-21-15 Petitioner presented to Old St. Francis Rock Cut Prompt Care in Loves Park ("OSF") where Dr. Asra Khan noted the following:

> Pamela L Beamus is a 43 y.o. female who sustained a right hand injury 3 day(s) ago. Mechanism of injury: was putting in tail lights at work, hit hard with hand, now swollen and painful since the weekend, some numbness in middle finger (Px 2, p. 51).

Petitioner reported no prior problems in her right wrist/hand. On exam, the doctor noted pain, tenderness and swelling mostly along the thenar eminence and mild numbness in the middle finger (Id.).

Right hand/wrist x-rays indicated a small bone spur at the right middle finger distal phalanx base laterally (Px 3, p. 86).

Dr. Khan diagnosed a right hand sprain and instituted a 10 lb. lifting restriction with no repetitive movements for 3 days. The doctor also prescribed pain medications and gave Petitioner a splint (Px 2, p.51).

On 1-21-15, Petitioner presented to Respondent's Plant Medical office ("Plant Medical") with complaints of right wrist pain after an injury on 1-19-15 at 3:30am. (PX 1). Petitioner reported the following history of accident:

> I was working on the line, I started with the Dart placing the front facial clip on and started to receive pain in my right hand. I continued to work and rotate through the line when I got to station 1905 working on the right side placing light fixtures. I was placing the rear light fixture into a Compass and went to push the light fixture in my hand started to receive pain and also began to swell up. I did report to my team leader Lakeisha Williams and Meesha, I also placed ice upon my hand. Eric was not available at the time, when he became available, I did report to him at this time, it was almost time for the shift to be over, so I took 2 Tylenol and finished the shift. I was asked if I wanted to come to medical.

Petitioner presented a light duty note to Respondent's Plant physician, Dr. Wellendorf, who noted:

> [O]btaining the accurate mechanism of injury was difficult with this employee. At first, she told me that she injured her right hand and wrist installing a rear light fixture on a Compass. This is also what her original workers statement reported. But, then after obtaining a detailed history from the employee, it became apparent that she felt that she was having problems before she installed the light fixture on the Compass. At our request in medical, employee filled out another workers statement. Employee had been working at this station for two seeks. Employee states that she was working on 1/19/15 (PX1, p. 4).

Dr. Wellendorf noted Petitioner did not have problems completing the "lengthy workers statements and writing with her dominant affected R hand" (Id.). The doctor also noted the Petitioner was wearing a "padded gloves" at the time of the alleged incident (Id.).

On exam, the doctor noted mild tenderness over the hypothenar region, proximal mid-thumb, and distal 3rd metacarpal -3rd proximal phalanx region and slight sift tissue swelling over proximal mid thumb (Id.). Petitioner was instructed to ice, elevate and wear her splint as directed. Dr. Wellendorf opined that Petitioner's alleged work injury was a "no trauma incident" (Id.).

Petitioner testified the work restrictions provided to Respondent were not accommodated as she was performing essentially the same tasks as before her injury (Tr. 16).

On 1-28-15 Petitioner underwent a right upper extremity EMG that was interpreted as normal with no evidence of active denervation (Px 3, p. 136).

On 1-28-15 Plant Medical noted Petitioner reported increased pain with twisting and pushing motions (Px. 1). She was wearing a splint and taking Meloxicam (Px 1).

On 2-4-15 Petitioner reported to Plant Medical that her right wrist felt better (Id.). Petitioner stated that she was doing her regular job with no problems and did not need restrictions (Id.). Petitioner also stated she was no longer taking medication, had no swelling, and only had slight residual discomfort (Id.). RN Rios noted that per a conversation with Eric Bertram, Petitioner's supervisor, Petitioner had been working full duty with no complaints (Id.).
On 2-12-15 Petitioner presented to Plant Medical where E Kastler, RN, noted Petitioner was wearing a support splint. Petitioner reported that twisting her wrist in a certain way caused pain and complained of numbness and tingling in the right middle finger and thumb along with problems gripping secondary to wrist pain. Petitioner presented a note from Dr. Martens at OSF Medical dated 2-10-15 in which Dr. Martens asked Respondent to honor Petitioner's light duty restrictions as Petitioner had reported to Dr. Martens that the previous light duty restrictions had not been honored (Px 1). Dr. Martens stated that Petitioner was restricted from lifting more than 10 lbs. or engaging in repetitive movements for 14 days. In addition, Petitioner was to wear a splint at work until further notice (Id.). Petitioner reported that due to seniority she was bumped to a different job, which she described as light and nonstrenuous. She did not believe the restrictions provided from Dr. Martens would impact her new job but said her doctor wanted them in place anyway (Id.).

On 2-27-15, Petitioner presented to Plant Medical after being totally disabled for her right wrist and hand injury from 2-13-15 to 2-26-15 (Id.). She was authorized to return to work on 2-27-15 with no restrictions (Id.).

On 2-28-15, a right wrist MRI performed at OSF Rock Cut Crossing noted:

1. Significant medial subluxation and possible rupture of the extensor carpi ulnaris (ECU);
2. Carpal tunnel unremarkable. Median and ulnar nerves grossly unremarkable;
3. No significant bone marrow edema to suggest acute fracture noted;
4. Early DJD at fourth metacarpal joint suspected due to mild edema (Px. 3, p. 99).

On 3-14-15, Petitioner presented to the emergency room at Swedish American after falling about 8 feet down some stairs (Px 4; Rx 19). She described pain in the dorsum of the right hand, left lateral ankle, decreased range of motion, and swelling. X-rays of the right hand were normal and Petitioner was diagnosed with a contusion to the upper extremity and an ankle sprain (Id.).

On 3-19-15 Petitioner treatment at OrthoIllinois where she reported a history of right wrist pain after hitting the front bumper with her hand while she was working on a car (Px. 5). She was diagnosed with subluxation of the left extensor carpi ulnaris tendon. She was recommended medication as well as an EMG to rule out peripheral nerve compression (Id.).

On 4-2-15 Petitioner underwent a right upper extremity EMG study at Ortho Illinois to rule out peripheral nerve compression (PX 5). The study showed cubital tunnel syndrome. Dr. Bear noted in his encounter records on 4-14-15 that the study showed mild right ulnar nerve conduction delay across the elbow, which was demyelinating but not axonal with no FDIM denervation. No evidence of carpal tunnel syndrome or other neuropathy was found (*Id.*).

On 4-13-15, Petitioner presented to OSF Rock Cut Crossing with a history of right hand pain and swelling after punching a wall (Id., p. 106). She was diagnosed with a middle phalangeal spiral fracture of her right ring finger (Id.).

On 6-8-15 Petitioner presented to OrthoIllinois for an occupational therapy evaluation regarding her (non-work) fracture in the middle phalanx of her right ring finger that occurred on 4-13-15 (Px 5, p. 308). The Arbitrator notes Petitioner reported to the therapist that she injured her finger at work when she "caught her finger at work on a hand drill" (Id.). Her main complaint concerned intermittent throbbing in the ring

finger and numbness in the tip of the finger. She also complained of right wrist pain and hand numbness that lasts the entire night. She had been working at her regular job. She was taking Norco as needed. A wrist splint was provided to be worn at work. Therapy was not ordered (Id., p. 306).
On 6-9-15 Dr. Bear at OrthoIllinois signed a return to work order with the requirement Petitioner wear cock-up wrist splint at work due to right wrist pain (*Id.*). Another note released Petitioner to work without restrictions related to closed-fracture of phalanx of finger (*Id.*).

On 8-7-15 Petitioner presented to Swedish American ER (PX 4). She reportedly noticed a small bump in her right inguinal area after shaving one week ago. She thought that it was a skin problem but started to gradually get larger. Petitioner said that the pain worsens with lifting and moving activity. Petitioner said that it started as pimple one week ago but got worse. A CT exam revealed a right inguinal hernia (*Id.*).
On 8-20-15 Petitioner presented to Plant Medical for a recheck of the right ring finger and right wrist (RX 1). She brought paperwork from Dr. Bear releasing her to return to work with the use of a splint on her right ring finger and right wrist. Dr. Bear noted a diagnosis of wrist pain and mallet deformity. Petitioner stated she was considering right wrist surgery. Petitioner was also seen for a reinstatement exam related to a hernia. She reportedly was scheduled for hernia surgery on 9-9-15 (Id.). Petitioner was reinstated to work through the surgery date (*Id.*).

Petitioner participated in physical therapy for her right wrist between 11-19-15 and 2-8-16 (Id.).

In February of 2016, Petitioner and Dr. Bear discussed the possibility of surgery to address her wrist injury. Petitioner did not want to proceed because, according to her testimony, she was concerned about her ability to heal from surgery and her ability to financially support herself (Tr. 24). Petitioner was released to work with 10-pound weight restrictions and instructions to wear a brace (*Id.*). Petitioner testified that she went back to her regular job for and then a few days later was moved to a test-driving role, which she performed for a few weeks (Tr. 25).

On 2-15-16 a repeat right wrist MRI was performed at OrthoIllinois to assess for a TFCC tear. A history of pain with repetitive movement and lifting was noted and a clicking in the wrist since 1-18-15 was noted. The MRI indicated:

1. Mild ECU tendinosis. No microtear;
2. Mild dorsal capsular swelling felt related to repetitive microtrauma. No intrinsic ligament tear. TFC and peripheral attachments intact;
3. Tiny 3.5 mm ganglion dorsal to the scapholunate interval.(Id.).

On 2-25-16 Petitioner was seen for an Independent Medical Examination ("IME") with Dr. Stephen Weiss (Rx. 5). Dr. Weiss diagnosed cubital tunnel syndrome and extensor carpi ulnaris, unrelated to her work injury. Dr. Weiss did not feel that Petitioner's work activities were forceful enough to cause the injuries (Id.).

On 2-25-16 an injection to Petitioner's right wrist was administered by Dr. Brian Bear at Ortho Illinois (Px. 5).

On 2-25-16 Petitioner was seen at Plant Medical for reinstatement at which time she presented light duty restrictions. Petitioner reported again to Plant Medical on 3-9-16. Petitioner testified she was told that if she was still on restrictions, she was not needed.

Plant Medical records indicate that Petitioner's restrictions regarding her hernia surgery (15 WC 34471) were lifted as of 3-21-16 (Px. 1). She remained restricted regarding her right wrist (Id.).

On 2-29-16 MRI ruled out the cervical spine as the cause of her ongoing right hand and wrist symptoms (Px 5, p. 328).

Petitioner returned to work around 3-31-16 with use of the wrist splint.

16 WC 16894
The Case at Bar

Petitioner alleges she aggravated her right wrist injury on 5-13-16 from continuously lifting a box, similar in weight to a gallon of milk in the performance of her work duties. She testified she repeatedly lifted and placed the box in every automobile, after which, she clamped and secured the box to the car (Tr. 26). She was excused from work and sought treatment at the emergency room (Id., 28). She returned to her regular job the next day (Id.). An Employer's First Report of Injury Form noted that on 5-13-16, Petitioner was connecting a hose to a water line when her hand slipped, striking it against a part in the car. She suffered a contusion and strain to her right wrist and hand (Rx. 14).

Petitioner testified that Dr. Martin took her off work in May of 2016 and she has not returned since (Id., 29).

On 5-17-16 Petitioner was seen by Dr. Bear at Ortho Illinois with complaints of right wrist pain and numbness/tingling in her hand. She described a "new injury to the right wrist on Friday night while at work" (Px. 5). Petitioner was again placed on restrictions. Dr. Bear recommended another MRI to rule out an occult fracture based on her history and exam findings. A 15 lb. weight restriction and instructions to wear a wrist splint while working were noted (Id.).

On 5-24-16, at her attorney's request, Petitioner was seen by Dr. Jeffrey Coe for an Independent Medical Examination. Petitioner reported to the doctor that her job involved pounding fascia in place with the palm of her right hand as well as installing tail lights. Dr. Coe opined that a causal relationship existed between Petitioner's work activities and her right hand and wrist symptoms. He noted her symptoms were consistent with ECU tendinitis and that additional treatment was necessary. He opined Petitioner should be restricted to light duty work with continued use of the right wrist splint while working (Px. 10).

On 5-26-16 Petitioner presented to Dr. Bear for a recheck of her right wrist pain and hand numbness. Her main complaint was pain at the ulnar aspect of her wrist with occasional swelling along with numbness/tingling in the entire hand, worse at night (Px 5.). Dr. Bear reviewed an updated right wrist MRI from 5-23-16 noting the ECU tendinosis had progressed slightly while a flat 5.3 mm ganglion cyst dorsal to the scapholunate interval was similar when compared to the previous exam (Id.). Additional conservative care was recommended. Petitioner did not return to work for Respondent after May of 2016.

On 6-19-16, Petitioner was seen for neck and back pain after a tree branch fell onto the trunk of the car she was sitting in. Petitioner underwent physical therapy for her left arm and neck from 6-28-16 through 9-7-16 (Px. 7). She began treatment with Dr. David Ian Smith on 9-12-16 due to left sided neck and arm pain from that accident (Px. 12).

On 11-16-2016 Petitioner underwent surgery performed by Dr. Bear at OrthoIllinois Surgery center. The preoperative diagnosis noted: right wrist occult dorsal carpal ganglion cyst, right wrist extensor carpal ulnaris subluxation, and right wrist possible triangular fibrocartilage complex injury. The procedure included right wrist arthroscopy, debridement, arthroscopic ganglion cyst removal, open extensor carpal ulnaris tenosynovectomy, stabilization of subluxation extensor carpi ulnaris tendon, and wrist block. The Postoperative diagnosis noted there was no evidence of triangular fibrocartilage complex tear. No complications were noted and Petitioner was discharged home (Px. 5).

On 11-30-16 Petitioner was seen postoperatively and placed in a long-arm cast (Id.).

Petitioner testified she moved to Minneapolis on November of 2016 (Tr. 59).

On 12-20-16 Petitioner began treating with David Ian Smith, DO, at Fairview Maple Grove Medical Center in Minneapolis for her right wrist. Dr. Smith noted he had instructions from Petitioners surgeon regarding aftercare for her wrist (Px 12, p. 825). The doctor removed her long-arm cast, instituting a short-arm cast (Id.).

On 12-24-16, Petitioner complained that the cast was too tight, causing numbness and tingling. The cast was removed and her arm was wrapped (Px. 8).

On 1-3-17, Petitioner was referred to occupational therapy (Px. 12).

On 1-4-17, Petitioner was involved in a motor vehicle accident while riding in the passenger seat when she braced herself with her right arm, striking it on the dashboard. X-rays revealed no fracture or dislocation at that time (Rx. 4).

On 1-10-17 Petitioner began physical therapy for her right hand at the Institute for Athletic Medicine (Px. 7).

On 1-13-17, Dr. Smith noted that Petitioner had injured her surgically recovering right wrist in a motor vehicle accident.

On 1-23-17 a repeat MRI of Petitioner's right wrist was performed which demonstrated a 1x 2.2. x 1.9 cm stabilizer within the subcutaneous soft tissue in the dorsal wrist. Diffuse osteopenia was appreciated secondary to disuse vs. chronic. Ulnar styloid showed bony edema (Px 12, p. 846).

Petitioner continued in physical therapy in Minneapolis through 2-17-17 (Px. 7).

Petitioner was referred to Dr. Amy Moeller for evaluation regarding the impact of the motor vehicle accident on Petitioner's implanted stabilization device. Dr. Moeller examined Petitioner on 3-20-17. After review of the 1-23-17 MRI, Dr. Moeller opined that there was not an acute etiology for her persistent pain noting that pain was expected 4 months out from her surgery, but that her symptoms were likely exacerbated by the car accident (Px. 12).

Petitioner resumed physical therapy at Fairview Maple Grove Medical Center and continued in therapy from through 6-8-17. On 4-27-17, Dr. Smith noted that physical therapy was going well, and Petitioner had regained some motion and strength in her right hand however, she still had difficulty gripping most things without pain and could not lift more than 10 lbs. without a setback (Id.).

On 6-23-17, Dr. Smith noted Petitioner's complaints of continued difficulty with her grip and with pain on the ulnar side of her wrist. He suggested a Functional Capacity Evaluation (Id.). The FCE was not approved and therefore not performed. Petitioner continued to complain of numbness in the hand. An EMG was recommended to rule out nerve entrapment. The EMG of 8-21-17 was normal (Id.).

Due to ongoing symptoms, Petitioner wanted to consider taking the stabilizer out of her arm. On 8-21-17, Dr. Smith referred Petitioner back to Dr. Moeller for surgical evaluation and on 10-2-17 Dr. Moeller noted Petitioner's complaints included difficulty opening jars and carrying grocery bags. Dr. Moeller explained that removing the stabilizer could cause more problems or lead to instability (Id.). Petitioner was seen by Dr. Ariel Williams for another opinion regarding the stabilizer and Dr. Williams agreed that removal of the stabilizer would almost certainly result in recurrence of Petitioner's ECU instability (Id.).

Petitioner continued to treat with Dr. Smith and on 1-25-18, Dr. Smith opined that Petitioner can work, but couldn't perform a job requiring repetitive use of her right wrist, frequently carrying objects exceeding

5-10 lbs., or tasks that require her to hold objects out at length (Id.). That opinion was reiterated by Dr. Smith on 11-7-18 in a letter articulating that Petitioner's condition and limitations are now likely permanent (Px. 13). Petitioner testified she provided her restrictions to Respondent and was informed they do not have work for her within her restrictions.

Dr. David Ian Smith was deposed on 2-1-19 (Px. 14). Dr. Smith testified that Petitioner should not lift more than 10 pounds on a repetitive basis. He did not feel that she could return to work for Respondent, based on her description of her position. He offered the opinion that her restrictions are now permanent. Dr. Smith testified that he did not feel the 1-3-17 motor vehicle accident materially changed the condition of Petitioner's wrist. He noted the MRI performed after the motor vehicle accident demonstrated a chronic appearance of the tendon, noting stenosis and a split tear that represent more of a chronic injury that was likely present before the motor vehicle accident. He noted the bony edema that was caused by the accident as well that did not correlate with a new injury to the already damaged tendon.

Dr. Stephen Weiss saw Petitioner for a second Independent Medical Examination on 4-30-19 (Rx. 6). At that time, Dr. Weiss was asked whether various intervening accidents, including the fall down stairs on 4-14-15, punching a wall on 4-13-15, falling down on 10-5-15, the 6-19-16 tree falling onto her car, or the 1-3-17 motor vehicle accident impacted her treatment or diagnoses. He indicated that Petitioner denied any permanent change in her status following those accidents and that "the treatment records I reviewed do not contradict this" (Rx. 6). Dr. Weiss continued to opine that Petitioner's work activities were not sufficiently forceful to cause her tendinitis or tendon subluxation. Dr. Weiss also opined that Petitioner could return to regular work activities (Id.).

Petitioner remains in physical therapy and is taking Gabapentin, Flexeril, and Percocet (Tr. 36-37).

Respondent submitted surveillance of Petitioner performing grocery shopping for approximately 10 minutes on 3-8-19 (Rx. 10). Petitioner stated that she worked delivering groceries at the end of 2017. Petitioner testified that she would decline to take orders that involved heavy lifting (Tr. 37). She stated that after carrying a gallon of milk or two, she realized that this irritated her injury, which made it hard for her to perform this job (*Id.*). Petitioner testified that she would work seven to eight hours performing this job per week (Tr. 38). Later in the hearing, Petitioner testified she last delivered groceries a few days prior to trial (Tr. 60).

In describing her current symptoms, Petitioner claimed that she is not able to stick a key in a door, has difficulties with daily cleansing of her own body, trouble with zippers and buttons, and difficulty writing with her right hand (Tr. 39). Petitioner stated that she has not looked for other work because she is not able to do much and in today's world repetitive motion is included in everything (Tr. 40). Finally, she stated that since May of 2016 she has not received any work comp benefits (Tr. 41).

Testimony of Eric Bertram

Respondent called Eric Bertram who testified that on the accident date he was a production supervisor for Group 11 which handled assembly of "TCF, trim, chassis and final" (Trans. 65). His job duties included supervising 60 people in 6 teams of 10, one of whom was Petitioner (Id.).

Mr. Bertram described the task of attaching the front bumper (aka fascia) noting that a vehicle is carried on a monorail system to the various plant stations (Trans. 68). An employee at any given station then has approximately 48-50 seconds to perform a series of activities. Regarding Petitioner's front bumper station, Mr. Bertram testified that two employees unwrap a canvas coated bumper which they carry back to the car and secure to the car with a series of "pushpins". The pushpins are hammered into place using a rubber mallet (Id.). The task is performed 120 times per 2 hour rotation. Mr. Bertram acknowledged that employees "could have" used their hand to force the pushpins into place although that would have gone against Respondent's standard procedure (Id.). He agreed workers could have been using their hands to do

the fascia job and he had not reprimanded anyone for doing so. Mr. Bertram also agreed that Petitioner was rotating between 3 positions, 2 hour shifts each in January of 2015. So, over a 10 hour shift, she would have repeated 2 of the positions. Mr. Bertram testified that he was consistently successful in finding accommodations for injured employees because of the wide array of stations at the Respondent's plant (Tr. 73.

CONCLUSIONS OF LAW

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

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

The Arbitrator finds that Petitioner's testimony is corroborated by the cotemporaneous medical records and Employer's First Report of Injury. Based on a preponderance of the credible evidence, the Arbitrator finds that Petitioner sustained her burden regarding this issue.

Regarding causal connection, the medical records subsequent to this accident indicate that Petitioner sustained a contusion. Her symptoms did not materially change after May 13, 2016. She was working with restrictions prior to May 13, 2016, had been in physical therapy only a month prior, and did not experience significantly increased symptoms thereafter.

Therefore, the Arbitrator finds that Petitioner's May 13, 2016 injury was a temporary exacerbation of her January 19, 2015 injury and is not causally related to her current condition.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC021038
Case Name	MILLER, HELEN v. STATE OF ILLINOIS, OFFICIAL
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0186
Number of Pages of Decision	24
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	Commission@kfeej.com
Respondent Attorney	Charlene Copeland AG CHICAGO WORKERS COMP

DATE FILED: 4/21/2021

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	)	[X] Reverse Accident	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HELEN MILLER,

Petitioner,

vs. NO: 17 WC 21038

STATE OF ILLINOIS-OFFICIAL
COURT REPORTERS,

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 in this claim and being advised of the facts and applicable law, reverses the Decision of the Arbitrator for the reasons outlined below, and finds that Petitioner sustained accidental injuries that arose out of and in the course of Petitioner's employment by Respondent on February 20, 2017. The Commission further finds in favor of Petitioner on the issues of notice, causal connection, medical expenses, and permanent partial disability (PPD) benefits.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings of fact:

1) Petitioner became a certified court reporter in June 2000. (T.10). She started working for Respondent at the Skokie courthouse in August 2007. (T.11).

2) Petitioner testified that she did not have any problems with her hands, and in particular with her left hand, when she began working for Respondent. (T.11).

3) Petitioner described her job duties and stated, "I took a verbatim record of court proceedings." (T.12). Petitioner explained that she would travel to different courtrooms within the Skokie courthouse and would haul her equipment that was encased in a rollaway luggage case. The case weighed approximately 50 to 70 pounds, and Petitioner would carry the luggage case up and down stairs. (T.12). Petitioner confirmed that she was left-hand dominant so she used her left hand to carry the equipment up and down the stairs. (T.13-14).

4) During cross-examination, Petitioner explained that she did not use the elevators at the courthouse because they were in an inconvenient location and many were not functional. (T.33). There were only two floors at the Skokie courthouse. (T.33).

5) The luggage case carried a machine that weighed about 20 pounds, a tripod, and microphone. (T.12).

6) Petitioner would sit in a chair that was available at the courthouse; Petitioner testified that the seating was not ergonomically friendly. (T.12). "I am a shorter person. So the seat was always too wide and I would have to either sit up and reach for my machine or sit back and try to lean my machine towards me." (T.13).

7) Petitioner testified that the court call ranged from 10 cases to 100 cases. She would keep track of the cases by writing down the case name using her left hand, returning to her machine, and making the record. (T.14). Petitioner would place her paperwork on a small bench in front of her. (T.14-15).

8) Petitioner stated that there were brief periods where she was not typing or writing names. "Maybe for a couple of seconds between the time cases are called or they are bringing prisoners in and out of lockup or people are stepping up to the podium." (T.15-16).

9) Petitioner described her work schedule:

> If I was downstairs in the misdemeanor rooms, there were usually three different call times. So it would be 9:00, 10:30 and 1:30. Then you would have a one hour lunch break. If I was in the felony rooms, I would start at 10:00 a.m. and it could go two hours up to 6:00 o'clock at night, depending. Then if I was on a trial, like a murder trial or some other criminal trial, it would usually be an entire day from 9:00 to 5:00 with an hour break. (T.16).

10) Petitioner explained the amount of pressure she used to type: "The stenographic machine is designed so you adjust the touch of the keys. However, you are still applying pressure. With each stroke you depress the keys. In one day you could have over 100,000 strokes." (T.17). Petitioner would also alternate positions each time a new case was called. (T.17).

11) After the court call, Petitioner would type and bind the transcript. "So I would use a heavy-duty stapler that staples up to 50 pages at a time and staple each transcript that I produced." (T.17-18). Petitioner would use her left arm "to apply a great deal of pressure to either hole punch my paper or bind my transcripts with heavy duty staples." (T.18).

12) Petitioner would type transcripts every day and she would sometimes work after hours. (T.18). "[I]t would depend if I was on trial. If I was in a big trial, then I would sometimes work through the night. If I had an overload of transcripts, I would work at home as well." (T.18-19).

13) Petitioner estimated that she would bind about five to 15 transcripts a week. (T.20).

14) Petitioner began noticing problems with her left hand in the beginning of 2017. (T.21). "My left hand kept falling asleep, tingling. When I would hold my pencil or any small object or do any fine motor type gripping with my left hand, it would go numb." (T.21).

15) Petitioner first sought treatment at Green Leaf Orthopaedics in Gurnee on February 20, 2017. (T.21). Petitioner was evaluated by Selina Carpenter, Physician Assistant to Dr. Thomas Baier, M.D. The medical history indicated that Petitioner was left-hand dominant and had worked as a court reporter for 17 years. Petitioner reported some neck soreness, as well as left hand and thumb numbness. Petitioner had noticed these symptoms for the past month. Examination revealed full range of motion in the left wrist, negative Tinel's, Phalen's was positive for numbness in the thumb, and Petitioner had no thenar or hyperthenar eminence atrophy. Petitioner was diagnosed with left carpal tunnel syndrome, predominantly the thumb. Dr. Baier recommended that Petitioner wear a brace at night and increase her Ibuprofen to 400 mg, three times a day. If Petitioner's condition did not improve, Dr. Baier would consider an EMG study or discuss surgery. (PX1).

16) The medical records indicated that Petitioner underwent therapy for her neck and left arm at Illinois Bone and Joint Institute from March 13, 2017 through April 19, 2017. (PX1).

17) Petitioner testified that she continued to perform her regular duties. (T.21-22). She notified her supervisor Nancy Naleway of her symptoms after her visit with Green Leaf – sometime in mid-March 2017. (T.22-24). "I just told her the symptoms I

was starting to have. That I visited an orthopaedic doctor, who recommended surgery. That I was probably going to get a second opinion because I was concerned about having surgery." (T.25). Petitioner stated that she continued to update Nancy as her symptoms progressed, "and as I started making decisions about how I was going to relieve my symptoms in my hand." (T.25).

18) Petitioner next consulted with Dr. Robert Gray on March 20, 2017 at NorthShore University Healthsystem in Lincolnshire. (T.25-26; PX2). X-rays of the left hand were unremarkable without acute fracture, subluxation, or significant degenerative changes. Dr. Gray examined Petitioner and noted that another physician had recommended a carpal tunnel release; Dr. Gray made the same recommendation. (T.26; PX2).

19) Petitioner testified that she informed Dr. Gray of her job duties. (T.26).

20) Petitioner admitted at arbitration that she could not recall if her first conversation with Nancy had been before or after her visit with Dr. Gray. (T.26).

21) Petitioner underwent a left open carpal tunnel release on May 25, 2017. (T.27; PX2). Petitioner continued to follow-up with Dr. Gray's office post-operatively through July 19, 2017. (PX2).

22) On March 1, 2018, Dr. Gray issued a letter To Whom It May Concern summarizing Petitioner's complaints and his examination. Dr. Gray indicated that Petitioner had had complaints "of left shoulder to hand pain and then numbness/tingling in the left Thumb up to left shoulder." Dr. Gray stated that Petitioner's shoulder complaints had started five months ago and that the numbness/tingling about two to three months ago. Dr. Gray had noted this timeframe in his first office visit note. Dr. Gray noted that Petitioner had an injection about 15 years ago after being casted; there were no additional details related to this. Dr. Gray indicated that his examination revealed positive Tinel's on her left hand/wrist but there was negative elbow Tinel's bilaterally. He further opined: "Due to her daily work activities as a court reporter, it is [probable] that her work activities could have exacerbated or aggravated her underlying carpal tunnel syndrome to flare and cause her the symptoms that she experienced prior to her surgery." (PX4).

23) Petitioner eventually returned to her regular duties for Respondent. (T.28). As of late 2017 or early 2018, Petitioner began working as a freelance court reporter. (T.28-29).

24) As of the date of arbitration, Petitioner testified that she still had a tiny bit of tingling and numbness in her thumb. "However, I am able to hold objects and write without my whole hand going numb. So it has relieved my symptoms greatly." (T.29). Petitioner also experienced a little bit of weakness. "I can't

necessarily completely put weight on the palm of my left hand because of the scar there." (T.29).

25) Respondent's Exhibit 1 is the Section 12 report of Dr. William Vitello of Chicago Orthopaedics & Sports Medicine dated June 5, 2019. Dr. Vitello's medical record review and recitation of Petitioner's job duties were consistent with the testimony and evidence presented at arbitration. His examination of Petitioner revealed no significant findings post-surgery.

26) Dr. Vitello stated:

> The number of hours she types does not affect the development of carpal tunnel syndrome. She states that she typed from five hours to eight hours a day. She does have breaks throughout the day. This type of activity of typing is not causally related or connected to the development of carpal tunnel syndrome. (RX1).

27) Dr. Vitello added:

> This activity is repetitive albeit although not a combination of heavy forceful or repetitive gripping, grasping, pushing, or pulling or prolonged awkward postures, all of which could lead to the development of carpal tunnel. Carpal tunnel syndrome is a commonly occurring condition in the general population and is largely considered to be [idiopathic] in nature. (RX1).

28) Dr. Vitello further found that notwithstanding causation, Petitioner's treatment had been reasonable and necessary. Petitioner did not require further medical care for the resolved left hand carpal tunnel and Petitioner could return to her regular duties without restrictions. Dr. Vitello stated that Petitioner had reached maximum medical improvement (MMI) on July 19, 2017 when she was discharged from her treating physician. (RX1).

29) Respondent's Exhibit 2 was the Workers' Compensation Employee's Notice of Injury that Petitioner had testified to signing. The information on the report was consistent with Petitioner's testimony at arbitration with respect to her job duties, her injury, and diagnosis. The form was dated May 26, 2017. (T.36-37; RX2).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator found that Petitioner failed to prove that an accident arose out of and in the course of her employment by Respondent. The Arbitrator based his Decision on Petitioner's reported complaints to Dr. Gray on March 20, 2017; on that date, Petitioner informed Dr. Gray that her left hand numbness and tingling began two to three months before. According to the Arbitrator, the evidence therefore demonstrated that Petitioner's left carpal tunnel symptoms manifested in January 2017 and not on February 20, 2017. As such, the Arbitrator found that Petitioner failed to prove that her repetitive trauma injury manifested on February 20, 2017.

"An employee seeking benefits for gradual injury due to repetitive trauma must meet the same standard of proof as a claimant alleging a single, definable accident." *Nunn v. Indus. Comm'n*, 157 Ill. App. 3d 470, 480 (1987). To prove a compensable injury, "an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person." *Durand v. Indus. Comm'n*, 224 Ill. 2d 53, 65 (2006). In the case at bar, Petitioner first began working for Respondent in 2007 as a court reporter. Although she had worked as a court reporter since 2000, there was no evidence of any prior medical history related to her left hand or wrist. After a decade of working as a court reporter for Respondent, Petitioner began noticing problems with her left hand in the beginning of 2017. Petitioner first sought treatment for her complaints with Dr. Baier's office on February 20, 2017; on that date, the Physician Assistant noted that Petitioner was left-hand dominant and that Petitioner had worked as a court reporter for 17 years, and noted Petitioner's symptoms and examination findings. Petitioner was diagnosed with left carpal tunnel syndrome.

The Commission finds that the Arbitrator erred in finding that Petitioner failed to prove that her repetitive trauma injury manifested on February 20, 2017 because she had informed Dr. Gray that her left hand numbness and tingling began two to three months before. "The date on which the employee notices a repetitive-trauma injury is not necessarily the manifestation date. Instead, the date on which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date." *Durand v. Indus. Comm'n*, 224 Ill. 2d 53, 68-69 (2006). Our Courts have long established that this standard is flexible. *Id.* The preponderance of the evidence demonstrated that Petitioner's condition manifested on February 20, 2017; this is the date that Petitioner first sought treatment for her complaints and became aware that she had left carpal tunnel syndrome as a result of her work duties, or in other words, this is the date when both the injury and its causal link to her work would have become plainly apparent to a reasonable person including Petitioner.

With respect to notice, the Arbitrator found that Petitioner's testimony regarding the date she notified her supervisor Nancy Naleway of her condition was vague. The Commission finds that Petitioner's testimony that she notified her supervisor sometime in mid-March 2017 was sufficient and within the 45-day deadline pursuant to Section 6(c)

of the Act; the deadline was April 6, 2017. The Commission notes that Petitioner had admitted at arbitration that she could not recall if her first conversation with Nancy Naleway had been before or after her visit with Dr. Gray on March 20, 2017. Respondent's response was that there was no evidence of an actual conversation between Petitioner and her supervisor.

Section 6(c) of the Act provides that either oral or written notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident.

> The purpose of the notice requirement is 'both to protect the employer against fraudulent claims by giving him an opportunity to investigate promptly and ascertain the facts of the alleged accident and to allow him to minimize his liability by affording the injured employee immediate medical treatment.' (Citation omitted). The notice is jurisdictional, and the failure of the claimant to give notice will bar his claim. (Citation omitted). However, a claim is only barred if *no* notice whatsoever has been given. (Citation omitted). 'If some notice has been given, but the notice is defective or inaccurate, then the employer must show that he has been unduly prejudiced.' *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 67.

Here, the Commission finds that Petitioner provided some notice of her injury which was sufficient under the Act. While Respondent argued that it was defective, it made no showing that it was unduly prejudiced. Respondent had ample opportunity to defend its position as well as secure a Section 12 examiner's opinion prior to the arbitration hearing. As such, the Commission reverses the Arbitrator's Decision and finds that Petitioner provided sufficient notice pursuant to the Act.

The Arbitrator also found that Petitioner failed to prove that her condition of ill-being was causally related to the alleged February 20, 2017 accident date. "An employee who alleges injury based on repetitive trauma must "show[ ] that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood Nursing Home v. Indus. Comm'n*, 115 Ill. 2d 524, 530 (1987). In repetitive-trauma cases, the claimant "generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability." *Nunn v. Indus. Comm'n*, 157 Ill. App. 3d 470, 477 (1987). In the case at bar, Respondent made no objection when Petitioner offered Dr. Gray's March 1, 2018 letter into evidence. Dr. Gray opined: "Due to her daily work activities as a court reporter, it is [probable] that her work activities could have exacerbated or aggravated her underlying carpal tunnel syndrome to flare and cause her the symptoms that she experienced prior to her surgery." (PX4). Respondent's Section 12 examiner Dr. Vitello stated:

> The number of hours she types does not affect the development of carpal tunnel syndrome. She states that she typed from five hours to eight hours a day. She does have breaks throughout the day. This type of activity of typing is not causally related or connected to the development of carpal tunnel syndrome. (RX1).

Dr. Vitello added:

> This activity is repetitive albeit although not a combination of heavy forceful or repetitive gripping, grasping, pushing, or pulling or prolonged awkward postures, all of which could lead to the development of carpal tunnel. Carpal tunnel syndrome is a commonly occurring condition in the general population and is largely considered to be [idiopathic] in nature. (RX1).

The Commission notes that Petitioner attributed her left carpal tunnel condition to several things: She was left-handed, her seating during court was not ergonomically-friendly, she applied pressure when depressing keys on the stenographic machine, she would type approximately 100,000 strokes in one day, she carried her 50-to-70 pound luggage case with equipment up and down stairs, and she applied pressure when binding transcripts. Petitioner testified that she completed five to 15 transcripts per week. By this description, Petitioner's combined work activities involved heavy forceful or repetitive gripping, grasping, pushing, pulling or prolonged awkward postures, all of which could lead to the development of carpal tunnel syndrome according to Dr. Vitello. Petitioner's testimony with respect to her job duties was unrebutted.

Based on the evidence in its entirety, the Commission reverses the Arbitrator's Decision and finds instead that Petitioner proved that her left carpal tunnel syndrome was the result of her repetitive duties for Respondent and that such condition manifested on February 20, 2017. The Commission further finds that Petitioner provided timely notice to Respondent pursuant to Section 6(c) of the Act.

By her Brief, Petitioner requests that if this Commission finds in her favor then she additionally requests that reasonable and necessary medical bills be awarded, specifically $348.00 to Greenleaf Orthopedics, $655.00 to Northshore Health, and reimbursement for out-of-pocket expenses. Petitioner did not dispute Respondent's right to an 8(j) credit. Respondent denied liability for medical benefits due to its dispute on accident, notice, and causal connection. Having determined that Petitioner's left carpal tunnel syndrome was the result of her repetitive duties for Respondent and that such condition manifested on February 20, 2017, the Commission awards the medical bills requested by Petitioner. The Commission notes that Respondent's Section 12 examiner, Dr. Vitello, indicated that notwithstanding causation, Petitioner's treatment had been reasonable and necessary.

By the request for hearing, Petitioner did not claim any temporary total disability benefits; Petitioner's attorney confirmed this on the record at arbitration. (T.6).

With respect to PPD, it is noted that the basis for Respondent's denial of payment for benefits was due to its position on accident, notice, and causal connection. Having found in favor of Petitioner on these issues, the Commission weighs the five factors under Section 8.1b of the Act as follows:

(i) Impairment Rating: The parties did not offer any impairment rating into evidence. Thus, the Commission give this factor no weight.

(ii) Occupation of Injured Employee: Following her left carpal tunnel release on May 25, 2017, Petitioner returned to her regular duties for Respondent. The Commission gives this factor some weight.

(iii) Petitioner's Age: Petitioner was 42 years old on the accident date; neither party submitted evidence into the record which would indicate the impact of the Petitioner's age on any permanent disability resulting from the February 20, 2017 accident. Nonetheless, the Commission takes into consideration that Petitioner must still live and work with her disability for a number of years. The Commission give this factor some weight.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: Evidence of Petitioner's disability is corroborated by the treating medical records. Petitioner underwent some therapy and a left open carpal tunnel release on May 25, 2017. Petitioner continued to follow-up with Dr. Gray's office post-operatively through July 19, 2017, and was eventually released to her regular job duties with Respondent. As of the date of arbitration, Petitioner testified that she still had a tiny bit of tingling and numbness in her thumb. "However, I am able to hold objects and write without my whole hand going numb. So it has relieved my symptoms greatly." (T.29). Petitioner also experienced a little bit of weakness. "I can't necessarily completely put weight on the palm of my left hand because of the scar there." (T.29).

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission awards Petitioner fifteen-percent (15%) loss of use of the left hand pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on April 21, 2020, a copy of which is attached hereto, is hereby reversed for the reasons stated above. Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent; Petitioner's injury

manifested on February 20, 2017; and Petitioner's current condition of ill-being with respect to the left hand/wrist is causally related to the February 20, 2017 accident. Petitioner also provided timely notice of the accident to Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and related medical bills, specifically, $348.00 to Greenleaf Orthopedics, $655.00 to Northshore Health, and reimbursement for out-of-pocket expenses, as provided in Petitioner's Exhibits 1 and 3, and pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $775.18 per week for 30.75 weeks, because the injuries sustained caused the fifteen-percent (15%) loss of use of the left hand under Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all other amounts paid, if any, including a credit under 8(j) of the Act, 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.

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: **4/21/2021**

/s/ *Thomas J. Tyrrell*

TJT/pm
O: 3/3/21
051

/s/ *Stephen J. Mathis*

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on March 3, 2021, before a three-member panel of the Commission including members L. Elizabeth Coppoletti, Stephen J. Mathis, and Thomas J. Tyrrell, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Commissioner Coppoletti on March 19, 2021, the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three-member panel, but no formal written decision was signed and issued.

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

/s/ *Deborah L. Simpson*

____

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0186
NOTICE OF ARBITRATOR DECISION

MILLER, HELEN Case# **17WC021038**
Employee/Petitioner

ST OF IL - OFFICIAL COURT REPORTERS
Employer/Respondent

On 4/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

APR 21 2020

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

21IWCC0186

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

Helen Miller
Employee/Petitioner

Case # **17 WC 21038**

v.

Consolidated cases:

State of Illinois-Official Court Reporters
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 **10/23/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

☐ TPD ☐ Maintenance ☒ TTD

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On **2/20/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**68,645.80**; the average weekly wage was $**1,310.50**.

On the date of accident, Petitioner was **42** 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

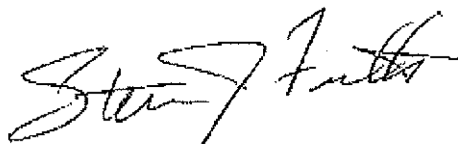
Respondent is entitled to a credit of $**0** under §8(j) of the Act.

ORDER

Petitioner's claim for benefits denied for Petitioner's failure to prove that an accident occurred that arose out of and in the course of her employment, and that she gave timely notice to her employment, and that she her claimed condition of ill-being was causally related to a claimed accident on February 20, 2017

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 13, 2020
Date

APR 2 1 2020

Helen Miller v. State of Illinois-Official Court Reporters
17 WC 21038

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***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?; ***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?

STATEMENT OF FACTS

Petitioner Helen Miller worked as a certified court reporter beginning in June 2000. She began employment with Respondent in August 2007. She testified that she had no difficulties with her hands prior to 201 prior to 2017 7. Petitioner was assigned to the Skokie (2d Municipal District) courthouse and worked there for 10 to 11 years in the Criminal Division.

Petitioner's daily responsibilities included taking a verbatim record of court proceedings. She carries her reporting equipment from the court reporters' room to the assigned courtroom. She takes the stairs if the courtroom is on the second floor. Her reporting equipment includes the stenograph machine and stand, along with a notebook. All of the equipment is carried in a roller-case. On cross-examination she testified that she takes the stairs because the elevators were not convenient. She added that the escalators often did not work.

Petitioner explained the set-up of her machine and microphone. She also explained that the chairs provided for reporters not ergonomically friendly and that she would have to reach for her machine. She eventually purchased a tilting tripod which helped. She said that the keys on her steno machine are adjustable but that she is still applying pressure and noted that she alternates positions each time she types. Petitioner testified that she is left hand dominant and that she would write down the name of the case, then return to her machine and record the information. She indicated that she had the paperwork in front of her on a small bench and that while in the courtroom, there were only a couple of seconds when she was not using her machine. She further testified

that her hands move constantly as she types and writes. She makes over 100,00 keystrokes a day. She also testified that she would get no breaks on busy days.

Petitioner explained that she types transcripts when someone orders a copy and she usually transcribes the testimony in her office or sometimes at home. She added that she binds the transcript when completed with a heavy-duty stapler. She testified that she types between 5 and 15 transcripts a week.

Petitioner first began noticing tingling and numbness to her left hand in 2017. She saw Selina Carpenter, PAC at Greenleaf Orthopedics February 20, 2017 (PX #1). She was noted as left hand dominant. Petitioner gave a history of being a court reporter. She complained of neck soreness and left hand/thumb numbness, which she had noticed for the past month. Petitioner was using a brace without much change. On examination she had full motion of the left wrist. Tinel's was negative at failings was positive for numbness in the thumb. She had a full range of motion in the neck with some pain. She was diagnosed of carpal tunnel syndrome and was referred for physical therapy. Petitioner was advised that if the wrist did not improve an EMG would be considered or surgery discussed. Dr. Thomas E. Baier repeated the examination and approved the care plan.

Petitioner continued to work with a brace and doing home exercises, which did not help. She had physical therapy at Illinois Bone & Joint Institute for her neck and her left wrist through April 19, 2017.

Petitioner testified that she notified Nancy Naleway of her problem "sometime" in March 2017 and that her doctor had recommended surgery. She did not remember the exact date when she notified her supervisor, but stated it was "mid-month." She kept Ms. Naleway informed until she had surgery in May 2017. Petitioner returned to work following surgery and worked at the Skokie courthouse until the end of 2017.

Petitioner sought a second opinion from Dr. Robert Gray on March 20, 2017 (PX #2). She was noted as right hand dominant. Petitioner gave a history that she was a court reporter and had pain in the left shoulder to the hand and tingling and numbness in her left thumb up to the shoulder. The shoulder pain started 5 months before and numbness/tingling about 2-3 months before. She described the symptoms as worse with activity and certain positions. She related her symptoms to activity at work and immediately after work. She denied nocturnal symptoms. She had tried a brace with no success. Petitioner had a history of "an injection after being casted."

Petitioner had a history of continuing headache and attention issues along with neck pain from a 2014 motor vehicle accident. It was noted that she had previously

declined surgery for her current complaints. Dr. Gray recommended open carpal tunnel release. On May 10, 2017 Petitioner agreed to surgery.

Petitioner underwent an open carpal tunnel release on her left wrist on May 25, 2017. She was off of work through June 19, 2017 when she was released by Dr. Gray with control pain and numbness and tingling result , but was paid her full salary. She used sick and vacation days. She is making no claim for temporary total disability compensation. Petitioner returned to her regular work as a court reporter in the Skokie courthouse. She worked there until June 2017.

Beginning in 2018, she began free-lance work and purchased a more ergonomic steno machine. She testified that her current work is less rigorous now. She testified that she still has a little tingling in her thumb and that she is unable to put weight on her left hand due a scar on the palm of her left hand.

Dr. Gray wrote a "To Whom It May Concern" letter March 1, 2018. He repeated Petitioner's history from the initial encounter on March 20, 2017. Dr. Gray repeated his examination findings of positive Tinel in the left hand/wrist but negative elbow Tinel. He noted the left carpal tunnel release on May 25, 2017 and an uneventful recovery. Dr. Gray opined that due to her daily work activities as a court reporter, it is probable that her work activities could have exacerbated or aggravated her underlying carpal tunnel syndrome to flare and cause her the symptoms that she experienced prior to her surgery.

Petitioner was seen by Dr. William Vitello for a §12 IME on June 5, 2017 (RX #1). Dr. Vitello had reviewed Petitioner's previous medical records from Physician's Assistant Selina Carpenter and Dr. Robert Gray. At the exam Petitioner reported that her left-hand numbness and tingling had resolved. She reported that she was longer working as a court reporter for Respondent. She reported that she types 5 to 8 hours a day but with breaks throughout the day. She was working independently, doing 3 to 4 depositions per week. Petitioner did not report any pre-existing injuries or health conditions or other medical history.

Dr. Vitello noted that there was no report of a specific accident. Petitioner listed date of injury February 20, 2017, when she filed a Worker's Compensation notice. Petitioner described how she set up her workstation when she reports verbatim court proceedings. On clinical examination was no swelling to the wrist and no tenderness to the radial, dorsal, ulnar, or volar aspect of the wrist. Median nerve compression was negative. There were negative Tinel's and Phalen's. Muscle strength was normal and there was no atrophy.

Dr. Vitello noted that Petitioner did not report a specific accident. She listed a date of "injury" as February 20, 2017, when she filed a Worker's Compensation claim. He noted that carpal tunnel complaints had resolved. Dr. Montalvo found no causal relationship between petitioner's condition and the reported accident. He noted that the type of work reported to them for a causal link to the development of carpal tunnel. Dr. Vitello noted that reporting is no different from data entry keyboarding. Although court reporting activity is repetitive, it is not a combination of heavy forceful repetitive gripping, grasping, pushing, or pulling or prolonged awkward postures, all of which can lead to development of carpal tunnel syndrome.

Petitioner's Exhibit #1, included a billing statement showing an unpaid balance of $348.00. Petitioner's Exhibit #3 with various billing statements from NorthShore University HealthSystem showing an unpaid balance of $that she had no difficulties 665.00.

Respondent's Exhibit #2 is Respondent's Notice of Injury form, dated May 26, 2017. Petitioner reported the date of injury as February 20, 2017 and that it arose from "using left hand in reporting motion on steno machine and laptop verbatim record."

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that an accident arose out of and in the course of her employment by Respondent.

Petitioner claims that she sustained a repetitive trauma, namely carpal tunnel syndrome in her left-hand, as a result of repetitive forceful typing in the course of her employment as an official court reporter. In order to prevail in such a case, petitioner must prove both the fact of the claimed injury and the causal relationship of the injury to her employment would have been plainly apparent to a reasonable person.

Petitioner testified that she had not had problems with her hands before 2017. However, in 2017 she noticed numbness and tingling in her left hand. She gave a history to Dr. Gray on March 20 that her shoulder pain began 5 months before and that her left hand numbness and tingling began 2-3 months before. These problems progressed to the point where she sought medical care February 20, 2017 at Greenleaf Orthopedics. She was examined by PA Selina Parker who diagnosed left sided carpal tunnel syndrome. The examination and diagnosis were confirmed by Dr. Thomas Baier.

Petitioner denied carpal tunnel syndrome symptoms prior to 2017. Petitioner gave histories to her healthcare providers that her symptoms began in January 2017. It seems likely that a reasonable certified court reporter would have connected the distinctive symptoms of carpal tunnel syndrome to their work activities. The evidence demonstrates the Petitioner's carpal tunnel symptoms manifested in January 2017 and not on February 20, 2017.

Therefore, as stated above, the Arbitrator finds that Petitioner failed to prove that she realized a manifestation of a repetitive trauma of carpal tunnel syndrome on February20, 2017.

D: What was the date of the accident?

For the reasons stated above, the Arbitrator also finds that Petitioner failed to prove that her repetitive injury manifested on February 20, 2017, for those reasons stated above.

E: Was timely notice of the accident given to Respondent?

The Arbitrator finds that Petitioner failed to prove that she gave timely notice of her claimed injury within the time proscribed by §6(a) of the Act.

The Arbitrator has found that Petitioner failed to prove that her claimed injury manifested on February 20, 2017. However, even given that February 20 was the date of manifestation of symptoms of carpal tunnel syndrome, Petitioner's testimony regarding the date she notified her Nancy Naleway, her supervisor, was so vague and imprecise that it does not rise to proof by the preponderance of the evidence.

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

The Arbitrator finds that Petitioner failed to prove that her condition of ill-being was causally related to the claimed accident on February 20, 2017.

Petitioner presented evidence by way of a March 1, 2018 "To Whom It May Concern" letter by her treating surgeon, Dr. Thomas Gray. The letter was written 8 months after Petitioner was discharged care by Dr. Gray. The letter was not written contemporaneously with Petitioner's care by Dr. Gray. Moreover, the letter is clearly a report prepared by the treating physician for use in litigation, in violation of §16 of the Act. Although the letter was admitted in evidence, due to the provisions of section 16 the Act, the Arbitrator finds the causation opinion stated in the letter neither credible nor persuasive.

In addition, the Arbitrator did not find Petitioner credible in her testimony regarding her work activities. The Arbitrator did not find Petitioner credible when she testified that courthouse elevators were inconvenient and so she chose to carry her

equipment up and down stairs. It is common knowledge that there are elevators in courthouses that are restricted to the exclusive use of court personnel, of whom Petitioner was one. Further, the Arbitrator did find Petitioner credible when she testified that she forcefully operated her stenographic machine and keyboard. Also, Petitioner's testimony of an unrelenting workday with few, if any, breaks was not credible.

Respondent's §12 examining physician, Dr. William Vitello, opined that the work activities described by Petitioner lacked the heavy forceful repetitive gripping, grasping, pushing, or pulling or prolonged awkward postures, which can lead to development of carpal tunnel syndrome. Even if credible, Petitioner did not testify to the heavy forceful repetitive motions described by Dr. Vitello which are likely to cause carpal tunnel syndrome.

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?

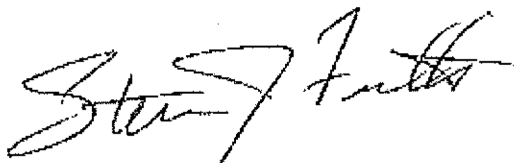
Inasmuch as the Arbitrator found that Petitioner failed to prove that her condition of ill-being was causally related to the claimed accident, this issue is moot.

K: What temporary benefits are in dispute? TTD

Inasmuch as the Arbitrator found that Petitioner failed to prove that her condition of ill-being was causally related to the claimed accident, this issue is moot.

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

Inasmuch as the Arbitrator found that Petitioner failed to prove that her condition of ill-being was causally related to the claimed accident, this issue is moot.



Steven J. Fruth, Arbitrator

April 13, 2020

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC016375
Case Name	NAVARRETE, ELPIDIO v. AALLIED DIE CASTING CO OF IL
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0187
Number of Pages of Decision	17
Decision Issued By	Christopher A. Harris, Commissioner

Petitioner Attorney	Jonel Metaj
Respondent Attorney	David VanOverloop

DATE FILED: 4/21/2021

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

ELPIDIO NAVARRETE,

Petitioner,

vs. NO: 18 WC 16375

AALLIED DIE CASTING COMPANY
OF ILLINOIS,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 19, 2020 is hereby affirmed and adopted.

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

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

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

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

DATED: **4/21/2021**

/s/ *Christopher A. Harris*

CAH/tdm
O: 4/15/21
052

/s/ *Barbara Flores*

/s/ *Marc Parker*

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

NAVARRETE, ELPIDIO Case# **18WC016375**
Employee/Petitioner

AALLIED DIE CASTING COMPANY OF ILLINOIS
Employer/Respondent

On 5/19/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JONEL METAJ
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

1505 SLAVIN & SLAVIN LLC
DAVID VanOVERLOOP
100 N LASALLE ST 25TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Elpidio Navarrete Case # **18 WC 16375**
Employee/Petitioner

v. Consolidated cases: -----

Aallied Die Casting Company 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 **Steven Fruth**, Arbitrator of the Commission, in the city of Chicago, on **October 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?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☐ TTD

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **January 13, 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 $**35,089.60**; the average weekly wage was **$674.80**

On the date of accident, Petitioner was **61** years of age, **married** with **0** dependent children.

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

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

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

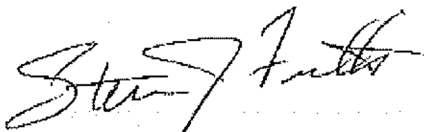
ORDER

Respondent has paid for reasonable and necessary medical services as of the date of trial, as provided in §8(a) of the Act.

Respondent shall authorize and pay for the left shoulder arthroscopic surgery recommended by orthopedic surgeon Dr. Brian Forsythe, pursuant to §8(a) of the Act, and any and all reasonable and necessary follow up medical care associated with this surgery.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 15, 2020
Date

MAY 19 2020

Elpidio Navarrete v. Aallied Die Casting Company of Illinois
18 WC 16375

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***K:*** Is Petitioner entitled to prospective medical care?

Petitioner testified through a Spanish language translator.

STATEMENT OF FACTS

Petitioner Elpidio Navarrete worked full-time for Respondent Aallied Die Casting Company of Illinois as a machine operator since 1984. He worked on a punch press machine 8 hours a day, pressing metal pieces weighing 6 to 7 pounds. He had to manually lift the pieces in and out of the press. He testified that he was also responsible for general cleanup of metal scraps and used a shovel to empty scraps into a trashcan. He did not do any overhead lifting of the metal pieces.

Petitioner testified that on January 13, 2018, he was performing his regular job duties when a piece of concrete from the ceiling fell onto his left shoulder, from a height of 30 to 35. The piece of concrete as being approximately the size of a baseball and weighing approximately 3 to 4 pounds. Petitioner testified that the piece of concrete hit him on the top of his left shoulder.

Petitioner felt immediate pain in his shoulder and notified his manager, who sent him to the company clinic. Petitioner testified that he had no pain complaints and was not in treatment for the left shoulder immediately prior to the January 13, 2018 work accident. He did have a left shoulder injury while working for Respondent approximately 10 years ago for which he had surgery (RX #6). However, he testified that he had been released by a doctor for that injury and he returned to full duty work for the Respondent in June 2009. He further testified that in the 10 years following this surgery, he has not had any pain in that shoulder and was able to perform his full duty work as a machine operator without any difficulty.

On January 13, 2018, Petitioner presented to Dr. Alan Sisson at US HealthWorks (PX #1). Petitioner gave a history of standing near a machine when a piece of cement fell from the ceiling, hitting and injuring his left shoulder. Petitioner gave his history of bilateral shoulder surgery. The examination of the left shoulder was generally benign. Dr. Sisson diagnosed a contusion of the left shoulder and noted that "the reported injury,

more likely than not was causing the current symptoms and findings." Dr. Sisson prescribed ibuprofen for pain management and returned Petitioner without restrictions.

Petitioner returned to Dr. Sisson January 23, 2018, complaining of a "grinding/ crunching" in the left shoulder. Petitioner was working with modified duty modified duty. Dr. Sisson diagnosed crepitus in the left shoulder joint, recommended an MRI, and returned Petitioner to work without restrictions.

Petitioner returned to US HealthWorks February 6, 2018 when he was seen by Dr. James John. Petitioner complained of a clicking sound with forcible flexion and extension of his shoulder. He was working his regular job duties. Petitioner denied numbness or tingling or weakness. There was no evidence of impingement. The diagnosis remained contusion of the left shoulder. Petitioner was again returned to work without restrictions.

On February 15, 2018, Petitioner presented to Bright Light Medical Imaging, where he had the MRI of his left shoulder (PX #2). The MRI demonstrated supraspinatus tendinopathy with marked tendon thickening and increased signal intensity, moderate acromioclavicular and glenohumeral joint degenerative changes, and artifacts from the surgical changes from a prior rotator cuff repair.

On February 20, 2018, Petitioner returned to Dr. Sisson who reviewed the MRI and noted significant tendinosis in the supraspinatus tendon of the left shoulder. Petitioner was still complaining of left shoulder pain with motion. It was noted he was working full duty. On examination there was a full range of motion of the left shoulder but there was also tenderness of the rotator cuff. Petitioner was discharged at his request in order to follow up with his own physician.

On February 27, 2018, Petitioner consulted with orthopedic surgeon Dr. Brian Forsythe at Midwest Orthopedics at RUSH (PX #2). Petitioner gave a history of the accident and complained of 6-7/10 pain in the left shoulder. He reported feeling 70% of normal functionality. Petitioner complained of shoulder pain and weakness, neck pain, and numbness into his hand.

On physical examination, Dr. Forsythe noted 135° of scaption, 40° of external rotation, and internal rotation to L5. He noted +1 tenderness to palpation along the greater tuberosity, +1 tenderness to palpation along the bicipital groove, and trace tenderness to palpation along the acromioclavicular joint. He also noted positive Speed's and Hawkins tests in the left shoulder. Dr. Forsythe reviewed the MRI and noted a possible small full-thickness rotator cuff tear. He recommended a course of physical therapy to improve pain levels, range of motion, and strength. He also prescribed an anti-

inflammatory and advised that Petitioner follow up in 5 weeks. Dr. Forsythe returned Petitioner to full duty work.

Petitioner received physical therapy from Athletico from March 5 through March 30, 2018 (PX #4).

On April 3, 2018, Petitioner returned to Dr. Forsythe for a follow-up. Petitioner complained of 6/10 left shoulder pain. Dr. Forsythe noted minimal improvement with 4 weeks of physical therapy and anti-inflammatories. He determined that Petitioner had failed with conservative measures. Dr. Forsythe recommended a left shoulder arthroscopy with rotator cuff repair, subacromial decompression, and biceps tenodesis. Dr. Forsythe kept the Petitioner at full duty work pending surgical approval.

Dr. Forsythe testified at his evidence deposition on April 16, 2019 (PX #3). Dr. Forsythe testified that Petitioner's left shoulder condition was aggravated by his work activities as a machine operator along with the incident that occurred on January 13, 2018. He testified that since Petitioner had a rotator cuff tear 10 years ago that was related to his work activities, and that he worked the same job for 10 years with a recurrence of that symptomatology, his opinion was that "in and of itself for me would declare this a work-related condition." Dr. Forsythe added that "the injury in January of 2018 was just one more thing to aggravate his condition."

Dr. Forsythe testified that he had not seen any records to indicate that Petitioner was in treatment for the left shoulder prior to the January 13, 2018 work accident. Dr. Forsythe opined that Petitioner's current condition of ill-being was aggravated by his work activities and January 13, 2018 work accident. He further opined that Petitioner will require arthroscopic rotator cuff repair, biceps tenodesis, decompression, and possibly a distal clavicle excision and the need for surgery is related to his work injury.

Petitioner's counsel asked Dr. Forsythe to review Dr. Balaram's IME report and chart notes from US HealthWorks. Respondent's objections to that testimony based on *Ghere v. Industrial Comm'n*, (1996) 278 Ill.App. 3d 840, were sustained and the responses relating to the documents were disregarded by the Arbitrator.

On cross-examination, Dr. Forsythe again testified that Petitioner's current left shoulder condition was "sequela of a previous work-related injury", citing the existence of the prior work injury as "the most compelling reason to establish causality." Dr. Forsythe also testified, "I wouldn't put too much stock in the temporal relationship given that ultimately his condition is most related to the prior work-related surgery ten years ago." On further cross-examination, Dr. Forsythe again stated, "ultimately if I were to provide an expert opinion as to what the underlying etiology of his condition is, I would say that it's the sequela of previous rotator cuff surgery which I have learned was work

related; therefore, this should be a work-related condition." Dr. Forsythe concluded that, "he [Petitioner] had a previous work-related shoulder surgery ten years prior, and that is the basis of the causal relationship in this case. The fact that he's suffering from the sequela of a previous work-related surgery renders this a work-related injury."

Dr. Forsythe acknowledged that there is a 10-20% risk of re-tearing a prior rotator cuff tear. He testified that Petitioner's condition was a sequela of his prior condition, which was incited by the work accident, which rendered it work-related.

Respondent retained Dr. Richard Suss to conduct an independent review of the February 15, 2018 left shoulder MRI. Dr. Suss testified by evidence deposition on August 19, 2019 (RX #2). His April 18, 2018 was admitted in evidence without objection.

Dr. Suss is board-certified in diagnostic radiology. He testified that his review of the February 15, 2015 MRI demonstrated metal artifacts from the previous surgery, physical thinning of the visible part of the supraspinatus tendon and degenerative features of the superior glenoid labrum with no finding of the long biceps tendon attached to it.

Dr. Suss opined that the images were consistent with a degenerative condition following surgical repair. He further opined that there was no evidence of an aggravation or acceleration of the degenerative condition caused by an acute incident. Petitioner's objection to those opinions based because they were not disclosed in Dr. Suss's report or disclosed before the deposition were sustained. The Arbitrator disregarded those opinions.

Dr. Suss testified that he did not conduct a physical examination, nor did he obtain a history or subjective complaints from Petitioner.

Respondent referred Petitioner for a §12 IME with orthopedic surgeon Dr. Ajay Balaram on May 1, 2018. Dr. Balaram testified by evidence deposition on June 18, 2019 (RX #1). His report dated May 9, 2018 and his addendum report dated May 29, 2019 were admitted in evidence without objection. Dr. Balaram is board-certified in orthopedics with an added qualification in hand surgery.

In addition to a clinical examination, Dr. Balaram reviewed Petitioner's medical records and diagnostic imaging. On examination Petitioner gave a history of being struck on the left shoulder by a piece of cement which fell from 25 feet above. Petitioner complained of shoulder pain which radiated into his neck. He also complained that shoulder pain radiated down his arm with some numbness in his hand. Dr. Balaram had Petitioner describe where the piece of cement hit him on the shoulder.

Petitioner had limited left shoulder range of motion, including forward movement to 110°, rotating away from the body to 35°, and rotating in toward the body to the midback. There were also findings consistent with rotator cuff inflammation and tendinopathy. Dr. Balaram noted the February 15, 2018 MRI showed the anchors from previous surgery as well as fraying or caring associated with supraspinatus tendon, which was consistent with chronic tendinopathy. He testified that he did not notice a full thickness rotator cuff tear. He also noted that Petitioner's initial medical records documented greater range of motion than at his IME.

Dr. Balaram diagnosed a left shoulder contusion and chronic rotator cuff tendinopathy and status post open left shoulder rotator cuff repaired ten years previous. Chronic tendinopathy is evidence of continued tearing of the rotator cuff after a surgical repair. Dr. Balaram opined that the rotator cuff tendinopathy or any partial tearing of the rotator cuff were not associated with or causally related to the contusion Petitioner sustained from the object falling onto his left shoulder. Dr. Balaram based this opinion on Petitioner's description of the mechanism of the injury. He noted that something falling onto the top of the shoulder would not cause an injury to the rotator cuff.

Dr. Balaram opined that the MRI findings were unrelated to the injury based on the mechanism of the injury. He noted that Petitioner had full range of motion immediately after the accident, which would indicate no rotator cuff injury or aggravation of the rotator cuff. Dr. Balaram further opined that reasonable and necessary care for a contusion would involve rest, ice, and treatment for the local cut in the falling object.

Dr. Balaram also reviewed multiple videos which indicated Petitioner's job related activities as well has a job analysis which described the heaviest weight lifted as 7 pounds and that an average operator lifts 3 castings at the time, or 21 pounds. The job does not require overhead work, but it does require reaching, lifting, and carrying between the waist and shoulder. Review of the videos did not change his previous opinions. The videos demonstrated what Petitioner was capable of performing after his accident.

Dr. Balaram also opined that Petitioner was at MMI, nearly 5 months after the injury.

On cross-examination, Dr. Balaram testified that chronic tendinopathy can be asymptomatic and patients with this diagnosis are able to perform their normal work duties. However, he added that someone with chronic tendinopathy would generally have symptoms. Dr. Balaram testified that there are none medical records that he reviewed indicated that Petitioner was symptomatic or treating for a left shoulder condition prior to the January 13, 2018 work injury. He further testified that irrespective of causation, Petitioner would be a candidate for arthroscopic if symptoms did not respond to conservative treatment such as therapy or possible cortisone injection. He added that

any surgery would not be related to petitioner's work accident. Dr. Balaram also testified that patients with a rotator cuff repair are at a 40-50% risk of a re-tear of the rotator cuff.

Respondent cross-examined Petitioner from four 4 video recordings, which were admitted in evidence (RX #4). Petitioner testified that all 4 videos accurately depicted his work activities. Petitioner testified that he was performing all of these duties without any difficulty prior to the accident and continued to perform the same duties following the accident. However, following the work accident, he had left shoulder pain while performing those same duties. He favored his dominant right arm in order to minimize the pain while working. He did not perform above the shoulder work for the Respondent and the videos did not depict any overhead lifting.

Petitioner testified that he retired from his Aallied in April 2018 and has not worked anywhere else since. He testified that he is still has pain in his shoulder going up his neck. That pain prevents him from lifting heavy items and from doing any activities above the shoulder level. Petitioner testified that he has not returned to Dr. Forsythe since his last visit on April 3, 2018 because the surgery has not been authorized. He testified that if the left shoulder arthroscopic surgery recommended by Dr. Forsythe is authorized, he would get it done right away.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that his current condition of ill-being is causally related to his work accident.

Petitioner was engaged in his normal work activities when a piece of cement the ceiling fell onto his left shoulder. Petitioner had a history of prior injury to both of his shoulders, each of which required surgery. A claimant must prove that some act or phase of her employment was a causative factor in her ensuing injuries. 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. Employers take their employees as they find them. 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 so long as it can be shown that the employment was also a causative factor.

In this case, Petitioner sustained an undisputed work-related accident on January 13, 2018. He credibly testified that he did not have any pain complaints and was not receiving any treatment related to his left shoulder prior to this work accident. There was no medical evidence presented at the hearing to indicate that Petitioner was symptomatic

or in treatment relative to the left shoulder prior to his accident. Petitioner testified that he had immediate pain after a piece of concrete fell onto his shoulder. He sought medical treatment immediately.

While Petitioner was able to perform his regular duty job following the accident, he testified that he did have pain in the left shoulder. The Arbitrator does not find that Petitioner's willingness and ability to work while in pain as a fact that breaks a causal connection between the accident and his symptoms. Petitioner's was able to work pain free prior to January 13, 2018, but developed the immediate onset of symptoms after the work accident. These facts alone are sufficient to establish a causal relationship between his subsequent condition of ill-being and his work accident.

Petitioner sought care from orthopedic surgeon Dr. Brian Forsythe. Dr. Forsythe examined petitioner and reviewed his left shoulder MRI. Dr. Forsythe diagnosed a possible small full-thickness rotator cuff tear, recommended a course of physical therapy, and prescribed an anti-inflammatory. On April 3, 2018, Dr. Forsythe noted Petitioner's minimal improvement with 4 weeks of physical therapy and determined that Petitioner had failed conservative measures. Dr. Forsythe then recommended a left shoulder arthroscopy.

At his deposition, Dr. Forsythe opined that Petitioner had a degenerative condition that was a result of his prior left shoulder injury and surgery. He opined that the work accident was an aggravating factor of Petitioner's degenerative condition and that surgery was necessary to relieve the effects of the aggravating event.

Respondent's examining physician, Dr. Ajay Balaram, examined petitioner and reviewed petitioner's medical records including the left shoulder MRI. Dr. Balaram also reviewed video recordings of work activities typical to petitioner's job. Dr. Balaram opined that Petitioner sustained a contusion of the shoulder on January 13, 2018 and that the Petitioner's current condition of ill-being, and need for the arthroscopic surgery, are related to his pre-existing chronic left rotator cuff tendinopathy, and not the work accident.

In weighing the conflicting causation opinions of Dr. Forsythe and Dr. Balaram the Arbitrator notes that the orthopedists noted that chronic shoulder tendinopathy may be asymptomatic and not necessarily disabling from work. However, the Arbitrator also notes that Petitioner credibly testified that he his left shoulder was asymptomatic since his prior injury and surgery and that he developed symptoms after the accident which led to a recommendation for arthroscopic surgery. Although Dr. Balaram relied heavily on Petitioner's description that the following cement hit him on top of his shoulder, Dr.

Balaram disregarded Petitioner's significant history of approximately 10 years without symptoms.

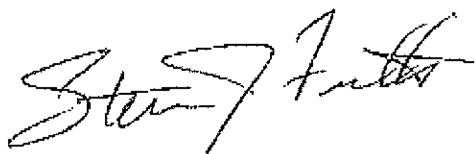
After reviewing the evidence, particularly the conflicting causation opinions by board-certified orthopedic surgeons, the Arbitrator finds the opinions of Dr. Forsythe reasonable and persuasive and adopts the same. The evidence is convincing that an asymptomatic Petitioner became symptomatic after his January 13, 2018 work-related accident.

K: Is Petitioner entitled to prospective medical care?

The Arbitrator finds that Petitioner proved that he is entitled to the prospective medical care in the form of an arthroscopic left shoulder surgery recommended by Dr. Forsythe.

Petitioner sustained an undisputed work-related accident on January 13, 2018. The arbitrator has found that petitioner proved that the current symptoms in his left shoulder our causally related to his accident. The Arbitrator's finding of causation was based on reasonable and persuasive opinions of Petitioner's treating orthopedist, Dr. Forsythe. It goes without saying that the Arbitrator did not find the causation opinions of Respondent's retained examining physician, Dr. Balaram, persuasive.

Dr. Forsythe found that Petitioner had failed conservative care. In fact, Dr. Balaram conceded that symptomatic chronic shoulder tendinopathy might require surgical intervention if conservative care failed. The facts are plain that Petitioner's conservative care had failed to cure or relieve the effects of the work accident. Accordingly, as above, the Arbitrator finds the opinion of Dr. Forsythe regarding the need for arthroscopic surgery is reasonable and persuasive, and further finds that Dr. Balaram's opinion that surgery is not necessary to treat injuries caused by the accident was not persuasive.



Steven J. Fruth, Arbitrator

May 15, 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC047179
Case Name	ROGERS, PATRICIA, MOTHER OF v. TERRY JOHNSON
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0188
Number of Pages of Decision	9
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Charles Webster
Respondent Attorney	Michael Casey, Ana Vazquez

DATE FILED: 4/21/2021

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

DACIA TIAVONNA ROGERS, a minor, by her mother and next friend, Patricia Rogers,

Petitioner,

vs. NO: 09 WC 47179

TERRY JOHNSON, a/k/a TANK JOHNSON, and State Treasurer as *Ex-Officio* Custodian of INJURED WORKERS' BENEFIT FUND,

Respondents.

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 evidentiary rulings, applicability of the Illinois Workers' Compensation Act, employer-employee relationship, and accident, and being advised of the facts and law, incorporates the conclusions set forth in companion case 09 WC 48168 and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 26, 2018, as modified above, is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: **4/21/2021** /s/ *Stephen Mathis*

mck

/s/ *Marc Parker*

O: 2/16/21

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 16, 2021, before a three member panel of the Commission including members L. Elizabeth Coppoletti, Stephen Mathis, and Marc Parker, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Commissioner Coppoletti on March 19, 2021, the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued.

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

/s/ *Deborah Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROGERS, DACIA TAIVONNA A MINOR BY HER MOTHER AND NEXT FRIEND ROGERS, PATRICIA
Employee/Petitioner

Case# **09WC047179**

09WC047181
09WC048168

TERRY JOHNSON AKA JOHNSON, TANK AND IWBF ETC
Employer/Respondent

On 12/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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.

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STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dacia Taivonna Rogers, a minor by her mother and next friend, Patricia Rogers
Employee/Petitioner

Case # 09 WC 047179

v.

Consolidated with: 09 WC 047181 & 09 WC 048168

Terry Johnson aka Tank Johnson and IWBF, etc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **8/22/18, 8/23/18, 8/24/18 and 8/28/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident 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 Insurance-Liability of the IWBF.

D. T. Rogers, etc. v. T. Johnson, etc., 09 WC 047179

FINDINGS

On **12/16/06**, Respondent ***was not*** operating under and subject to the provisions of the Act.

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

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

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

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

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

On the date of accident, Decedent was **26** years of age, ***single*** with **3** dependent children.

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that Respondent was operating under and subject to the Illinois Workers' Compensation Act and that an employee-employer relationship existed between Decedent and Respondent.

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

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

Signature of Arbitrator

December 21, 2017
Date

ICArbDec p. 2

DEC 2 6 2018

INTRODUCTION/PROCEDURAL BACKGROUND/DISPOSITION

This case and its two companion cases arise out of the fatal shooting of William B. Posey ("Posey") on December 16, 2006. The cases seek death benefits under the Workers' Compensation Act for Posey's three children, Tashonne Posey, Dacia Rogers and Andrew Rogers and they were brought by the children's mothers, Tamika Jones and Patricia Rogers, respectively ("Petitioners"). It is claimed that Posey's death arose out of and in the course of his employment by Terry Johnson ("Johnson"). It is also claimed that Johnson did not have workers' compensation insurance and, thus, the Injured Workers' Benefit Fund ("IWBF") is liable for the claimed benefits. Johnson disputed liability, primarily on the basis of no employee-employer relationship and the IWBF, as is customary, disputed all issues.

The Findings of Fact and Conclusions of Law herein are those set forth in Case No. 09 WC 048168. For the said reasons, the claim for compensation herein is denied.

21IWCC0188

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC047181
Case Name	ROGERS, PATRICIA, MOTHER OF v. TERRY JOHNSON
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0189
Number of Pages of Decision	9
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Charles Webster
Respondent Attorney	Michael Casey, Ana Vazquez

DATE FILED: 4/21/2021

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

ANDREW LORENZO ROGERS, a minor, by his mother and
next friend, Patricia Rogers,

Petitioner,

vs. NO: 09 WC 47181
09 WC 47179
09 WC 48168 (cons.)

TERRY JOHNSON, a/k/a TANK JOHNSON, and State
Treasurer as *Ex-Officio* Custodian of INJURED WORKERS' BENEFIT FUND,

Respondents.

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 evidentiary rulings, applicability of the Illinois Workers' Compensation Act, employer-employee relationship, and accident, and being advised of the facts and law, incorporates the conclusions set forth in companion case 09 WC 48168 and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 26, 2018, as modified above, is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: **4/21/2021**

/s/_*Stephen Mathis*_________

mck

/s/_*Marc Parker*___________

O: 2/16/21

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 16, 2021, before a three member panel of the Commission including members L. Elizabeth Coppoletti, Stephen Mathis, and Marc Parker, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Commissioner Coppoletti on March 19, 2021, the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued.

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

/s/_*Deborah Simpson*________

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0189

ROGERS, DACIA TAIVONNA A MINOR BY HER MOTHER AND NEXT FRIEND ROGERS, PATRICIA
Employee/Petitioner

Case# **09WC047181**

09WC047179
09WC048168

TERRY JOHNSON AKA JOHNSON, TANK AND IWBF ETC
Employer/Respondent

On 12/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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.

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D. T. Rogers, etc. v. T. Johnson, etc., 09 WC 047181

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dacia Taivonna Rogers, a minor by her mother and next friend, Patricia Rogers
Employee/Petitioner

Case # 09 WC 047181

v.

Consolidated with: 09 WC 047179 & 09 WC 048168

Terry Johnson aka Tank Johnson and IWBF, etc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **8/22/18, 8/23/18, 8/24/18 and 8/28/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
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☐ 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 **Insurance-Liability of the IWBF.**

D. T. Rogers, etc. v. T. Johnson, etc., 09 WC 047181

FINDINGS

On **12/16/06**, Respondent ***was not*** operating under and subject to the provisions of the Act.

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

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

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

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

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

On the date of accident, Decedent was **26** years of age, ***single*** with **3** dependent children.

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that Respondent was operating under and subject to the Illinois Workers' Compensation Act and that an employee-employer relationship existed between Decedent and Respondent.

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

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

Signature of Arbitrator

December 21, 2017
Date

ICArbDec p. 2

DEC 2 6 2018

D. T. Rogers. etc. v. T. Johnson. etc., 09 WC 047181

INTRODUCTION/PROCEDURAL BACKGROUND/DISPOSITION

This case and its two companion cases arise out of the fatal shooting of William B. Posey ("Posey") on December 16, 2006. The cases seek death benefits under the Workers' Compensation Act for Posey's three children, Tashonne Posey, Dacia Rogers and Andrew Rogers and they were brought by the children's mothers, Tamika Jones and Patricia Rogers, respectively ("Petitioners"). It is claimed that Posey's death arose out of and in the course of his employment by Terry Johnson ("Johnson"). It is also claimed that Johnson did not have workers' compensation insurance and, thus, the Injured Workers' Benefit Fund ("IWBF") is liable for the claimed benefits. Johnson disputed liability, primarily on the basis of no employee-employer relationship and the IWBF, as is customary, disputed all issues.

The Findings of Fact and Conclusions of Law herein are those set forth in Case No. 09 WC 048168. For the said reasons, the claim for compensation herein is denied.

21IWCC0189

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC048168
Case Name	JONES, TAMIKA, MOTHER OF v. JOHNSON, TERRY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0190
Number of Pages of Decision	19
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Charles Webster
Respondent Attorney	Michael Casey, Ana Vazquez

DATE FILED: 4/21/2021

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

TASHONNE KENYATTA POSEY, a minor, by her mother and next friend, Tamika Jones,

Petitioner,

vs. NO: 09 WC 48168

TERRY JOHNSON, a/k/a TANK JOHNSON, and State Treasurer as *Ex-Officio* Custodian of INJURED WORKERS' BENEFIT FUND,

Respondents.

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 evidentiary rulings, applicability of the Illinois Workers' Compensation Act, employer-employee relationship, and accident, and being advised of the facts and law, provides supplemental analysis but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The parties raised multiple challenges to the Arbitrator's evidentiary rulings. The Commission has analyzed every such instance and we affirm the Arbitrator's rulings. We write separately, however, to address the parties' arguments on two rulings in particular: 1) the admissibility of the police reports, and 2) the applicability of the Dead-man's Act.

I. Admissibility of Police Reports

Respondents argue the reports of Det. Baumann and Comm. Gaughan, Petitioner's Exhibit D and Petitioner's Exhibit A respectively, are inadmissible hearsay which do not fall

within the exceptions in Rule 803 or 804, and are further hearsay within hearsay barred by Rule 805. The Commission finds the police reports were properly admitted.

Initially, the Commission finds the public records exception applies to the officers' statements in the reports. Ill. R. Evid. 803(8). We further find PXD satisfies Rule 805 as Decedent acknowledging ownership of the marijuana is a statement against interest as contemplated by Rule 804(b)(3) (Ill. R. Evid. 804(b)(3)). Ill. R. Evid. 805. See *Kress Corp. v. Industrial Commission*, 190 Ill. App. 3d 72, 78 (1989) "'Hearsay within hearsay, often referred to as double level or multiple hearsay, is admissible if each of two or more statements falls within an exception to the Hearsay Rule.' (E. Cleary & M. Graham, Handbook of Illinois Evidence § 805, at 472 (3d ed. 1979).)" Turning to PXA, the Commission finds it was properly utilized in Petitioners' attempt to impeach Chavez.

Having considered each exhibit and weighed the evidence therein in the light most favorable to its proponents, the Commission nonetheless finds the police reports do not alter our ultimate conclusion that no employer-employee relationship existed between Decedent and Respondent.

II. Dead-Man's Act

Petitioners point to two questions which they argue are barred by the Dead-Man's Act:

1) When you asked Po to come live with you, invited you to come live with you in 2005, did you explain or stated to him that the relationship was one of employer/employee where you were going to employ him to do any activities for you (8.23.18 T. 148), and

2) And during that time period did you ever state to him or explain to him that a relationship between you and him was one of employer and employee (8.23.18 T. 152).

The Commission observes Petitioners' Counsel did not object to Question 1 at trial but did raise an objection to Question 2.

The Dead-Man's Act provides:

> In the trial of any action in which any party sues or defends as the representative of a deceased person ***, no adverse party or person directly interested in the action shall be allowed to testify on his or her own behalf to any conversation with the deceased *** or to any event which took place in the presence of the deceased ***. *735 ILCS 5/8-201* (West 2018).

The primary objective of the Dead-Man's Act is fairness. *Balma v. Henry*, 404 Ill. App. 3d 233, 238, 935 N.E.2d 1204 (2010). It is intended to remove the temptation of a survivor to testify

about matters that cannot be rebutted because of the death of the only other party to the conversation or witness to the event. *Id*. Thus, the Dead-Man's Act bars only that evidence the decedent could have refuted. *Gunn v. Sobucki*, 216 Ill. 2d 602, 609, 837 N.E.2d 865 (2005). Stated differently, evidence of facts that the decedent could not have refuted is not rendered inadmissible by the Dead-Man's Act. See *Rerack v. Lally*, 241 Ill. App. 3d 692, 695, 609 N.E.2d 727 (1992).

The Commission finds Petitioners' objection was properly overruled. The predicate for application of the Dead-Man's Act is that a party "sues or defends as the representative of a deceased person." Petitioners herein are not suing as representatives of Decedent; rather, Section 7(a) of the Act creates a cause of action for a surviving child in his/her own right, in his/her individual capacity. As such, we find the Dead-Man's Act is inapplicable.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 26, 2018, as modified above, is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: **4/21/2021** /s/_*Stephen Mathis*_

mck

/s/_*Marc Parker*_

O: 2/16/21

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 16, 2021, before a three member panel of the Commission including members L. Elizabeth Coppoletti, Stephen Mathis, and Marc Parker, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Commissioner Coppoletti on March 19, 2021, the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued.

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

/s/ *Deborah Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION **21IWCC0190**

NOTICE OF ARBITRATOR DECISION

POSEY, TASHONNE KENYATTA A MINOR BY HER MOTHER AND NEXT FRIEND JONES, TAMIKA
Employee/Petitioner

Case# **09WC048168**

09WC047179
09WC047181

JOHNSON, TERRY AKA JOHNSON, TANK AND IWBF ETC
Employer/Respondent

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T. K. Posey, etc. v. T. Johnson, etc., 09 WC 048168

STATE OF ILLINOIS)
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- [ ] 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

Tashonne Kenyatta Posey, a minor by her mother and next friend, Tamika Jones
Employee/Petitioner

Case # 09 WC 048168

v.

Consolidated with: 09 WC 047179 & 09 WC 047181

Terry Johnson aka Tank Johnson and IWBF, etc.
Employer/Respondent

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DISPUTED ISSUES

A. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
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[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other Insurance-Liability of the IWBF.

T. K. Posey, etc. v. T. Johnson, etc., 09 WC 048168

FINDINGS

On **12/16/06**, Respondent ***was not*** operating under and subject to the provisions of the Act.

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

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

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

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

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

On the date of accident, Decedent was **26** years of age, ***single*** with **3** dependent children.

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that Respondent was operating under and subject to the Illinois Workers' Compensation Act and that an employee-employer relationship existed between Decedent and Respondent.

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

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

Signature of Arbitrator

December 21, 2017
Date

ICArbDec p. 2

DEC 2 6 2018

INTRODUCTION/PROCEDURAL BACKGROUND

This case and its two companion cases arise out of the fatal shooting of William B. Posey ("Posey") on December 16, 2006. The cases seek death benefits under the Workers' Compensation Act for Posey's three children, Tashonne Posey, Dacia Rogers and Andrew Rogers and they were brought by the children's mothers, Tamika Jones and Patricia Rogers, respectively ("Petitioners"). It is claimed that Posey's death arose out of and in the course of his employment by Terry Johnson ("Johnson"). It is also claimed that Johnson did not have workers' compensation insurance and, thus, the Injured Workers' Benefit Fund ("IWBF") is liable for the claimed benefits. Johnson disputed liability, primarily on the basis of no employee-employer relationship and the IWBF, as is customary, disputed all issues.

A hearing was held on August 14, 2018 regarding a certain subpoena response by the Chicago Bears Football Club ("the Bears"). A record was not made on that day, as the Parties declined. Testimony was taken in these cases on August 22, 2018 and August 23, 2018. Exhibits were submitted on August 24, 2018. A Motion to Re-Open Proofs was heard on August 28, 2018 and additional exhibits were submitted on that date. The Parties stipulated to amend Petitioners' Exhibit 13 by attaching a missing page to an evidence deposition transcript on December 6, 2018.

Arbitrator's Exhibit 1 is the non-privileged documents from the Bears' subpoena response. Arbitrator's Exhibit 2 is the document from the Bears' subpoena response that the Arbitrator determined to be privileged after an in-camera review. The document was sealed in an envelope and surrendered to the Secretary of the Workers' Compensation Commission to be held for further review by future tribunals as the matters progresses beyond the arbitration level. These exhibits were admitted for the record and not as substantive evidence. Arbitrator's Exhibit 3 is the Request for Hearing ("RFH") in case number 09 WC 47179. Arbitrator's Exhibit 4 is the RFH in case number 09 WC 47181. Arbitrator's Exhibit 5 is the RFH in case number 09 WC 48168. Arbitrator's Exhibit 6 is an Order granting Petitioner's Motion to Reopen Proofs on August 28, 2018. Arbitrator's Exhibit 7 is the Parties' Stipulation to Amend Petitioner's Exhibit 13 to include a missing page from a deposition transcript.

Petitioner tendered 21 exhibits at trial, 11 of which were admitted in evidence. Petitioner's Exhibit A was a police report authored by Gurnee Commander Jeremy Gaughan. Petitioner's Exhibit D was a police report authored by Gurnee Detective Matthew Baumann (Ret.). There were no Petitioner's Exhibits B or C. Petitioner's Exhibit 1 was a NCCI no coverage statement regarding Terry Johnson, of Gilbert Arizona, on December 16, 2006. Petitioner's Exhibit 2 was an Administrative Paternity Order from the Illinois Department of Healthcare and Family Services establishing paternity for Posey as to Andrew Rogers, DOB: 6/10/2006, mother: Patricia Rogers. Petitioner's Exhibit 3 was DNA testing results regarding Posey and the three children, establishing 99.99% certainty that Posey was the children's father. Petitioner's Exhibit 4 was billing for the DNA testing. Petitioner's Exhibit 5 was the Post Mortem examination regarding Posey. Petitioner's Exhibit 13 was the Evidence Deposition of Lorrinda Johnson, taken 8/7/2018. Petitioner's Exhibit 14 was evidence photos of guns taken from Johnson's house by the Gurnee Police Department on 12/14/2006. Petitioner's Exhibit 17 was the birth certificate for Andrew Lorenzo Rogers (6/10/2006). Petitioner's Exhibit 18 was the birth certificate for Dacia Taivonna Rogers (12/27/2004). Petitioner's Exhibit 19 was the birth certificate for Tashonne Kenyatta Posey (3/13/2006).

Petitioner's Exhibits 6 through 12 and 15 and 16 were rejected.

Respondent's Exhibit 1 was withdrawn. Respondent's Exhibit 2 was a Certification from the Illinois Department of Financial and Professional Regulation, stating that Posey did not ever hold a license under the Illinois Private Detective, Private Alarm, Private Security and Locksmith Act. Respondent's Exhibits 3-6 were portions of the Private Detective, Private Alarm, Private Security and Locksmith Act (225 ILCS 447/Article 5, 10, 15 and 25). Respondent's Exhibit 7 was the disbursement Order in a civil case filed against the bar where Posey was shot (07 L 013334, Tamika Jones, etc., et al v. Ice Bar, et al, entered on December 19, 2013. Respondent's Exhibit A was a written statement that Lorrinda Johnson wrote on 12/14/2006, in connection with Commander Gaughan's report.

FINDINGS OF FACT

Testimony of Respondent, Terry Johnson

Petitioners called Respondent, Johnson, as an adverse witness in their case-in-chief. Respondent Johnson is a former Chicago Bears football player and is currently self-employed as a consultant for the National Football League.

Johnson testified that he and Posey had known each other for many years, as they were childhood friends. In 2006, Johnson did not employ Posey as his security guard. Johnson did not tell anyone that he employed Posey as his security guard. He did not hear Posey tell anyone that he (Posey) was employed by him. Posey was Johnson's friend and Johnson's goal was to make Posey's life better and keep Posey out of harm's way. Posey had been incarcerated in the past and the friends had reestablished their relationship after Posey was released from jail. The relationship appears to the Arbitrator to have been friends/roommates. Johnson let Posey stay at his house.

In 2006, Posey moved into Johnson's home in Gurnee, Illinois. Johnson could not recall the exact date that Posey moved in, but thought it was at the end of July 2006 or beginning of August 2006. Posey had his own bedroom at Johnson's house. Posey lived with Johnson until his death.

Johnson had four dogs at his home at that time. While Posey lived with Johnson, Posey did not feed the dogs. Johnson said that Posey was afraid of the dogs. Johnson had a dog caretaker that cared for the dogs. Posey did not do any yard work at the house. Johnson had a landscaper. Johnson and Posey would pick up after themselves as best they could. Posey would cook for the household maybe once a month. Posey may have taken out the trash. Posey did not pick up Respondent Johnson's dry cleaning, do his laundry, or run errands for him. Johnson did not give Posey any directions on what to do around the house. Posey did not pay Johnson any rent and there was no agreement between Johnson and Posey regarding payment of rent. Posey did not pay Johnson to eat. Posey sometimes lived with Johnson for more than forty hours in a week. Posey would stay with his sister and dad on the weekends when Johnson was out of town for an away game, or when he was staying in a hotel the night before a Bears home game. Posey would take Lorrinda Chavez (Johnson) ("Lorrinda"), Johnson's girlfriend at that time, to the grocery store if Johnson was out of town and she did not know how to get to there. Posey took Lorrinda Christmas shopping maybe once.

Johnson gave Posey money from time to time so that Posey could fend for himself while Johnson was out of town and Posey returned to his neighborhood on the South Side of Chicago. Johnson would give Posey whatever cash he had on his person or what was in the car cup holder. He did not give Posey checks to cash, a credit card, or a debit card. Johnson did not keep records of what amount of money he gave to Posey. Johnson did not claim any tax deductions for what he gave to Posey.

Posey would accompany Johnson to Bears games. Posey was not at the games to protect Johnson from overly enthusiastic fans. Johnson was 6'3" and weighed over 300 pounds. Posey was 5'8" or 5"6" and was a strong man.

Johnson owned several vehicles, including a BMW, Denali, Dodge and a Chevelle. Johnson did not like Posey driving his cars because he drove his car on one occasion and scratched it, so Johnson did not ask Posey to drive his car again. Johnson would drive himself to Soldier Field for games. He did not give Posey his car keys to pick up guests. He also did not ask Posey to drive guests to and from the airport. However, Posey may have taken Johnson's car without telling him.

Johnson testified that there were guns inside his home. They were registered only to him and he used them for sport and hobby. Johnson kept a loaded long gun on his dresser, where it was always kept unless he was going to a gun range. Johnson kept the long gun in his bedroom just as a precaution and for self-protection. Other guns were kept in a storage closet. Posey did not have Johnson's permission to use any of Johnson's guns to protect the house or Johnson's family.

At some point, Posey shot a gun outside Johnson's house, in an effort to get the dogs' attention. As a result of neighbor complaints, a search warrant was served on Posey and Lorrinda at Johnson's house on December 14, 2006. Cannabis and several firearms were found and confiscated by the Gurnee police. Posey was arrested for possession of cannabis. Johnson was charged with several weapons offenses, as he did not have a valid FOID card.

Johnson determined that Posey had to move out of Johnson's house. On December 15, 2006, they packed Posey's belongings and went out to dinner at Gibson's in Chicago with Mia Waites, a neighbor. They went via limousine. They ate dinner with two friends of Posey. Johnson paid for dinner. They then went to Ice Bar, on North Clark St. in Chicago, Illinois at maybe 11 p.m. Johnson did not expect Posey to protect him that night.

While at Ice Bar, a man repeatedly bumped into Johnson on the dance floor. Posey got into a fight with that man. Johnson did not expect Posey to protect him from the man, as there was nothing from which Johnson needed to be protected. Johnson told Posey not to do anything, but Posey intervened anyway and started hitting the man who had bumped into Johnson. Both men were throwing punches at each other. Security and Johnson tried to break up the fight, but they got into it again. Johnson walked away when it appeared that the other man's friends were going to get involved.

Johnson then heard one gun shot. He asked Posey if he had been shot and Posey said he had. Johnson left the Ice Bar and went to the limo. The limo driver took Johnson and Waites to Northwestern Memorial Hospital. Johnson was advised by the police that Posey was dead. Johnson did not see who shot Posey, but the man who bumped Johnson is currently in jail for killing Posey.

Johnson testified that he did not have workers' compensation insurance on December 16, 2006. He was not registered as self-insured and does not understand what that means. He did not file anything with the Illinois Workers' Compensation Commission about self-insurance.

On Direct examination, Johnson testified that he met Posey in 8th or 9th grade. Posey and Respondent Johnson were on the same high school football team at McClintock High School in Tempe, Arizona. They became friends and their friendship continued until Posey's death.

In 2004, Johnson was drafted into the National Football League by the Bears. Johnson bought a house in Gurnee, Illinois shortly after being drafted. Posey initially came to live with Johnson, at the Gurnee house, in 2005. Johnson asked Posey to live with him because of their friendship and because he knew that Posey had just been released from prison. Johnson wanted to give Posey the best chance to be successful. Johnson was 23 years old when Posey first came to live with him. Posey was 24. Posey's living with Johnson was not an employment relationship. Posey was incarcerated for a second time in late 2005 through early 2006 and did not live with Johnson during this time. Posey was incarcerated for being a convicted felon in possession of a gun.

After Posey's release from prison in Spring 2006, Johnson invited Posey to come back and live with him. Johnson testified that he had not given up on Posey. Posey continued to live with Johnson until Posey's death.

There was no employer-employee relationship between Johnson and Posey. Johnson did not ever tell Posey that their relationship was one of employer-employee. It was a friendship and Posey was Johnson's roommate.

While living at the Gurnee house, Posey did everyday activities and cleaned up after himself. Johnson cleaned up after himself. Johnson had landscapers that mowed the yard or shoveled snow on a weekly basis. He also had "dog guys" that would clean out the dog kennels and feed the dogs. Johnson also walked and fed his dogs. Posey was afraid of the dogs without Johnson being around. Johnson did not direct Posey to vacuum. Johnson did not direct Posey to fold laundry. Johnson also did not like anyone driving his cars, so he never asked Posey to pick up anyone at the airport. Johnson testified that he maybe gave Posey permission once to drive his car, but that overall, Johnson liked to do things for himself. Johnson would give Posey money if Johnson were going out of town and Posey was going to go to the South Side. Johnson did not want Posey to do anything foolish for money. Johnson also maybe gave Posey money for his birthday. He did not give Posey more than $10,000.00 and Johnson did not pay any gift tax for the money he gave to Posey. Johnson paid for "everything," so Posey did not need money. He never gave Posey an envelope with money.

Johnson kept between six and eight guns inside his house in Gurnee. He brought the guns with him to Illinois from Arizona. Johnson testified that he kept the guns for hunting and shooting targets, which were hobbies and stress relievers.

Johnson testified that on December 15, 2006, he, Posey, and Waites left his home between 8 p.m. and 9 p.m. The purpose of going out that night was to move Posey back to the South Side of Chicago. It was thought to be in Johnson's best interests to not have Posey living with him. Johnson, Waites, and Posey went to dinner, then went to Ice Bar in Chicago. They arrived at Ice Bar between 11 p.m. and 12 a.m. They were escorted to the VIP area. Johnson, Waites, and Posey stopped to dance to a popular song on the way to the VIP area. The nightclub was crowded.

Johnson testified that he was moving to the music when someone dancing behind him repeatedly bumped into him. Johnson wanted to make that person aware that he was bumping into him. They had a pleasant conversation and shook hands. Then the person called his friend over and Johnson and the friend also shook hands. Words were exchanged, but the exchange was not hostile or aggressive. Johnson testified that there were no physically threatening gestures made towards him by the man who had been bumping into him. Johnson resumed dancing after shaking hands with the two men. Posey then walked over and Johnson told Posey that there were no problems.

Johnson testified that Posey was upset about the police raid at Respondent Johnson's home the day before; when the guy asked Posey who he was, Posey lost his cool and punched the guy in the face. Johnson tried to break up the fight and he asked Posey to stop fighting. Johnson retreated from the situation because he did not want the

guy's friends to think that he was joining the fight. Then he heard a gunshot and Posey had been shot and later died. Johnson paid for Posey's funeral.

Johnson said that he did not employ Posey to protect Lorrinda and their children in his absence. He also testified that Posey's statement to the police after the raid, (Petitioners' Exhibit D), that Posey worked for Respondent Johnson and was paid $1,000 per week, was not correct.

Testimony of Lorrinda Johnson

Lorrinda Johnson testified in Petitioners' case-in-chief via evidence deposition. Lorrinda is Respondent Johnson's wife. On December 16, 2006, she had only been living at the Gurnee home for three or four weeks. She first met Posey when she moved in, but she knew that Posey had been Johnson's friend since high school. Johnson had informed her that Posey was living with him and he stated that he was helping Posey stay out of trouble.

Posey did not do any lawn care. Johnson paid a maid to clean the home every Sunday and paid a separate service to take care of his dogs. Posey washed his own clothes. Posey did not run errands or pick up dry cleaning for Johnson. Posey maybe drove Lorrinda twice to the store in order for her to learn her way around Gurnee. Posey also picked her and the children up from the hospital once. Johnson usually drove her and their children everywhere. Posey would just hang out with Lorrinda and her two children and watch cartoons. He did not babysit the children, nor did Lorrinda ever ask Posey to babysit. Posey would make meals for the household at least once a week, but everyone would serve themselves. While living with Johnson and Lorrinda, Posey mostly stayed in the basement.

Lorrinda testified that during her interview with Gurnee Police on December 14, 2006, she told the officer that Posey did work around the house, such as making dinner and contributing to household chores.

Lorrinda did not see Johnson hand Posey any money. She does not know Posey's sources of income. Johnson did not give Posey a credit card for household items. Lorrinda had no knowledge regarding whether Johnson paid Posey with checks.

Lorrinda testified that the guns in the Gurnee house belonged to Respondent Johnson and Posey was not responsible for them, nor did he have access to them. Johnson was the only person with access to the guns and was the only person who handled the guns.

Testimony of Retired Detective Matthew Baumann

Retired Gurnee Detective Matthew Baumann's testified at Petitioners' request and laid the foundation for admission of Petitioners' Exhibit D, a police report outlining an interview with Posey on 12/14/06. Posey said that he lived with Johnson in Gurnee for about a year. He has a residence in Chicago where his kids and their mother live. Posey said that he worked for Johnson doing things around the house and was paid approximately $1,000.00 per week.

Testimony of Commander Jeremy Gaughan

Petitioners also called Commander Jeremy Gaughan as a witness. His testimony laid the foundation for admission of Petitioners' Exhibit A, Supplemental Offense Report. Commander Gaughan testified that his Supplemental Offense Report is not verbatim, and is actually his summary of the conversation he had with

Lorrinda on December 14, 2006. In the report, he noted that Lorinda stated that "...Willie works for Terry. He takes care of his house and drives them around." He testified that Lorrinda also gave a written statement following his interview. After reading the written statement (Respondent Johnson's Exhibit A), Commander Gaughan agreed that there was nothing in the written statement about Posey working for Johnson.

Testimony of Lisa Helma

Lisa Helma was called as a witness by Petitioners and testified that she is a Rehabilitation Counselor at Vocomotive.

Helma testified that the average hourly wage for a security guard/personal bodyguard in 2006 was $12.29 and the annual salary was $25,550.00. The hourly wage for a houseworker in 2006 was $9.85 and the annual salary was $20,480.00. A houseworker is someone who would provide any type of work around the house, such as cooking, cleaning, letting vendors in, and taking care of pets.

In 2006, an individual could not serve as a personal bodyguard without being licensed. A convicted felon could also not serve as a personal bodyguard. Helma never met with Posey and did not have any information regarding Posey's background qualifications in regards to the vocational assessment she provided.

Testimony of Jerrod Johnson

Jerrod Johnson is Posey's brother. On one occasion, Posey, Johnson, and one other Bears player went to Jerrod's family residence on Hermitage Street in Chicago, Illinois ("Hermitage Residence") when Jerrod was present. On that occasion, Posey showed Jerrod a gun that Jerrod observed Posey retrieve from the armrest of Johnson's vehicle. Posey had the gun tucked in his pants and said that the gun was to protect Johnson. Johnson did not say anything in response to Posey's statement. This is the only time Posey ever showed Jerrod a gun.

Jerrod testified that he had gone to Johnson's home in Gurnee on two or three occasions. The first time Jerrod visited, besides observing guns on the first floor of the house, Jerrod also observed Posey cooking, vacuuming, and walking around the house picking things up. Posey was cooking on the stove in the kitchen. Jerrod heard Johnson give Posey instructions to vacuum the floor and clean the dishes. Jerrod testified that Posey waited five minutes, then began vacuuming the downstairs area rug. This was the only occasion that Jerrod saw his brother ordered around by Johnson.

While at Johnson's house, Jerrod also observed Posey driving Respondent Johnson's vehicle. Posey left the house and came back in Johnson's vehicle. Jerrod also testified that Posey would pick up a Chicago rapper from the airport in either Johnson's BMW or Denali. He observed the rapper in Johnson's car with Posey driving. He also observed Posey driving Johnson's vehicle with Lorrinda as the passenger and Posey stated to Jerrod that he was taking her shopping.

Jerrod observed Johnson give Posey money on one occasion. Johnson gave Posey an envelope that contained "a lot" of hundreds. Jerrod did not know the purpose of the money.

Testimony of Tamika Jones

Tamika Jones was also called as a witness in Petitioners' case. Jones testified that she is the mother of Tashonne Posey, born in March 2006, and that Posey is Tashonne's biological father.

After Posey was released from prison in May 2006, Posey resided with Tamika at her residence, as well as living with Johnson. After May 2006, Posey began living with Johnson full-time. Tamika went to Johnson's home on one occasion to celebrate Mother's Day 2006 and Johnson showed her Posey's bedroom. Johnson did not tell Tamika anything about Posey working for him. She might have observed Posey trying to straighten up the house, but noted that Posey was a tidy person by nature, and there was not much to tidy up in the residence.

After Tashonne was born, Posey saw her as much as he could, which was almost every day when he was not at Johnson's residence. Posey gave Tamika money for Tashonne every other week, sometimes $200.00, sometimes $100.00. She never saw Johnson give Posey money and Johnson was never present when Posey gave her money.

Testimony of Tashonne K. Posey

Tashonne testified in Petitioners' case-in-chief. She provided her date of birth and current address. She testified that she lives with her mother and was going to begin the seventh grade.

Testimony of Antoine Hunt

Hunt testified at the request of Petitioners. On December 16, 2006, Hunt was at Ice Bar with a couple of friends. While he was on the dance floor, people in the VIP area were bumping into people on the dance floor. At some point, a fight broke out on the dance floor. He testified that the "football player's security guard" was involved in that fight. Hunt testified that he saw Michael Selvie, another bar patron, try to grab a woman's "booty" and got into a fight with the "football player's security guard," Posey. The first punch was thrown by Posey, and it was thrown immediately after Selvie tried to grab the woman. Hunt saw Selvie pull a gun from his waist, heard one shot fired, then saw someone on the floor. Hunt saw Posey get shot in the arm. The next day, he learned Posey had died.

Hunt did not know any of the people involved in the shooting. He found out after the incident who the individuals were that were involved. Hunt had no personal knowledge of who the individuals involved were or what their relationships were to each other. His characterization of Posey as a "security guard" came from the newspaper.

Testimony of Anthony Johnson

Anthony Phillip Johnson ("Anthony") is also Posey's brother. Anthony testified that he met Johnson on several occasions. In 2005, Anthony was staying at a halfway house after being released from federal prison and Johnson and Posey visited him while he was there. They had a woman from Washington State with them who was visiting Johnson. Respondent Johnson told Anthony that Posey worked for him and that Posey had picked up the woman from the airport.

On another occasion, Anthony observed guns in the weight room at Johnson's home. At this same visit, Posey left the house in one of Johnson's cars and he had liquor with him when he returned. Anthony observed Johnson give Posey money for the liquor.

Anthony observed Posey driving Johnson's vehicle three or four times. Anthony was at Johnson's home a total of three times. He saw Posey cleaning up the house on only one of those occasions. He also observed Posey walk the dog and sort clothes in the basement.

In September or October 2005, Anthony saw Johnson at the Hermitage Residence. Jerrod, Anthony, Posey, Johnson and two other Bears players were present. They were all just talking; nothing stood out about this gathering.

Anthony testified that he had one felony conviction. He testified that Posey did not go to prison in 2005 through 2006, but he also then testified that he did not recall if Posey had gone to prison. Then he testified that Posey had gone to prison once that he knew about.

Testimony of Mia Waites

Mia Waites testified at the request of Johnson. Waites and Respondent Johnson were neighbors in Gurnee. Illinois. She knew Posey through Johnson and was social friends with them. She had been to Respondent Johnson's home "on occasion." She was with Johnson when Posey was shot.

On December 15, 2006, Waites accompanied Johnson and Posey to dinner and, afterwards, to a bar/nightclub. When they arrived, she and Johnson went to the dance floor and were moving to the music. She did not recall where Posey was while she and Johnson were dancing.

At some point, Selvie bumped into Johnson a couple of times. Selvie bumped into Johnson because of the crowded floor, and the contact was not aggressive in nature. Johnson and Selvie shook hands and it looked like there were no issues between them. No loud words were exchanged between Johnson and Selvie. There was no threatening or aggressive physical contact between Johnson and Selvie. Waites did not think that Johnson was in danger. Johnson also shook hands with Selvie's friend and was not ever under any threat of being harmed by Selvie's friend. After they all shook hands, Johnson and Waites continued to dance.

Selvie then bumped into Johnson again. It was not intentional or forceful contact. Posey came over and said, "hey, you're bumping into my friend." Johnson did not call Posey over. Johnson did not give any indication or make any motion for Posey to come over to the situation and he did not indicate to Posey that he needed help dealing with Selvie. Posey and Selvie then exchanged some words and started fighting. No words were exchanged by Johnson during this altercation. Waites did not observe Johnson participate in the fight. Selvie and Posey were fighting on the floor for a couple of minutes; when she heard a gunshot.

After the gunshot, the crowd dispersed. Waites left the bar/nightclub after the gunshot and she did not go back to check on Posey. When she left Ice Bar, she did not know Respondent Johnson's whereabouts. Upon leaving, she stayed with a crowd in front of the bar until she saw the limo driver, who took her back to the limo. Johnson was already inside the limo. The driver took them to the hospital, where they learned that Posey had died.

Regarding Posey's relationship with Johnson, Waites saw Posey tend to the dogs, but "he was staying there." Johnson did not tell her that Posey was his employee. She did not observe Johnson give Posey money. She did not observe Posey drive Johnson's vehicles. Waites does not have knowledge of Posey being Johnson's security guard. She testified that nothing she observed indicated that Posey was Johnson's security guard.

Patricia Rogers did not appear on any of the hearing dates and, of course, provided no testimony in favor of her children's claims.

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)

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

A. Act and B. Employer/Employee Relationship:

Petitioner has failed to prove that Respondent was operating under and subject to the Act and that there was an employee-employer relationship between Decedent, Posey and Respondent, Johnson.

This finding is based upon the entirety of the evidence adduced and the credible testimony of Respondent, Johnson.

In order for there to be an employee/employer relationship, there must be a contract of hire, express or implied. Thompson v. The Industrial Commission, 351 Ill. 356, 360 (1933) The definition of "employer" under the Act requires that the "employer" have "any person in service or under any contract of hire, express or implied, oral or written and is engaged in an enterprise set forth in Section 3 of the Act, or has elected to become subject to the Act. The term "employee" is defined as any person in the service of another under any contract of hire…" 820 ILCS 305/1(a)2, 820 ILCS 305/1(b)2

There was no evidence that there was a contract of hire between Johnson and Posey. Accordingly, the Act did not apply to their relationship and there was no employee-employer relationship between them. Johnson's testimony establishes that he never employed Posey as a driver, housekeeper or security guard. Posey was a friend that Johnson tried to help out after he had been released from prison. They were roommates. Johnson gave Posey a place to live, paid for his food and included him in daily activities. Without testimony establishing a contract of hire, Petitioners' claims must fail.

The proofs submitted by Petitioners do not convince the Arbitrator that Posey was an employee of Johnson. Johnson had a landscape contractor and had dog guys. Johnson let Posey stay at his house, without Posey paying rent. Posey sometimes cooked and sometimes cleaned. Johnson cleaned up after himself, as well. Posey cared for the dogs sometimes. Posey drove Johnson's cars sometimes and probably ran errands for his friend/roommate sometimes. Sometimes Johnson gave Posey money. Posey said that he was working security for Johnson. Posey said that a gun that he carried was to protect Johnson. None of these anecdotal events, or any of the other evidence convinces the Arbitrator that an employee/employer relationship existed between Posey and Johnson.

Considering the above, the Arbitrator gives no weight to Anthony Johnson's testimony that Respondent, Johnson told him that Posey worked for him. Respondent, Johnson's credible testimony and that of Lorrinda Johnson and Mia Waites persuade the Arbitrator that Johnson did not employ Posey in any capacity.

The credible evidence does not support a finding of employee-employer relationship. If there is no employer, the Act does not apply. Thus, the claim for compensation is denied on the basis that Petitioner failed to prove that Respondent Johnson was operating under the Act and that an employee-employer relationship existed between Decedent Posey and Respondent Johnson.

C. Accident, D. Date of Accident, E. Notice, F. Causal, G. Wages, H. Age, I. Marital Status/Dependency, J. Medical Expenses, K. Temporary Benefits, L. Nature and Extent, M. Penalties, N. Credit, and O. Insurance-Liability of the IWBF:

As the Arbitrator has found that Petitioner failed to prove an employee-employer relationship between Posey and Johnson and failed to prove that Johnson was operating under the Act, the Arbitrator needs not decide the above issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC041181
Case Name	GARCIA, FILIBERTO v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0191
Number of Pages of Decision	26
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	Joseph Spingola
Respondent Attorney	Stephanie Lipman

DATE FILED: 4/21/2021

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

Filiberto Garcia,

Petitioner,

vs. NO: 14 WC 41181

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, maintenance, temporary partial disability, benefit rate, credit and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator, as set forth below, and otherwise affirms and adopts, said decision being attached hereto and made a part hereof.

§8(d)1 of the Act provides, in pertinent part, that:

"If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall… receive compensation for the duration of his disability, subject to the limitation as to maximum amounts fixed in paragraph (b) of this section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning ***or is able to earn*** in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later." (Emphasis added).

As the Arbitrator noted, two valid functional capacity evaluations placed Petitioner at a medium physical demand level, significantly below the "very heavy" physical demand level associated with his former concrete laborer job. Thus, Petitioner is prevented from returning to his usual and customary line of employment and is entitled to a wage differential award. However, the Commission disagrees with the Arbitrator's determination that Petitioner's average post-raise earnings at McDonald's is a fair measure of his current earning capacity on which to base the §8(d)1 weekly benefit rate. More to the point, the Commission does not believe that this part-time job (which the Arbitrator found consisted of an average of 29.06 hours every two weeks or 14.53 hours per week) is the best Petitioner can do, either from a medical or even an economic standpoint, as the Arbitrator maintains. Indeed, there is no medical or vocational opinion that would limit Petitioner to such a part-time position, and every indication is that he is quite ready, willing and able to work full-time, albeit in a less physically demanding position than his prior concreate laborer job. In fact, Petitioner noted that he has been seeking such a full-time position, evidencing both an ability and desire to do so. Thus, the Commission finds that Petitioner is able to earn $480.00 per week based on a 40-hour work week and using the $12.00 per hour rate he is currently earning with McDonald's – an hourly rate that falls within the projected rate of pay anticipated by both Petitioner's and Respondent's vocational experts.

Thus, the Commission modifies the Decision of the Arbitrator to find that the proper wage differential rate pursuant to §8(d)1 of the Act is equal to $778.67 per week (2/3 [$1,648.00/week - $480.00/week]), commencing on 12/15/18, the date after the hearing at arbitration.

The Commission also notes that the TPD rate of $867.03 was properly calculated by the Arbitrator in that it reflects "… two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and *the gross amount which he or she is earning* in the modified job provided to the employee by the employer or in any other job that the employee is working", pursuant to §8(a) of the Act. As a result, the actual amount earned is to be used in calculating the TPD rate.

Finally, the Commission corrects a scrivener's error in the Arbitrator's decision as to the period of TTD finding that Petitioner was temporarily totally disabled from 10/17/14 through 10/19/17, or a period of 157 weeks (not 156-6/7), including the extra leap year day in 2016.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/4/19 is affirmed and adopted as modified herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $994.49 per week for a period of 157 weeks, from 10/17/14 through 10/19/17, 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 in the amount of $994.49 per week for a period of 18-5/7 weeks, from 10/20/17 through 2/27/18, under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary partial disability benefits in the amount of $867.03 per week for a period of 41-3/7 weeks, from 2/28/18 through 12/14/18, under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary outstanding prescription costs to ADCO (PX10), pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on 12/15/18, Respondent pay to the Petitioner the sum of $778.67 per week until such time the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later, as provided in Sec. 8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitates him from pursuing the duties of his usual and customary line of employment.

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

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

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: **4/21/2021**

o: 2/23/21
TJT: pmo
51

/s/ *Thomas J. Tyrrell*

/s/ *Barbara N. Flores*

PARTIAL DISSENT

I respectfully disagree with the majority opinion awarding temporary partial disability (TPD) benefits from the date Petitioner returned to work to the date of hearing, and awarding wage differential benefits to commence on the date of hearing.

§8(a) provides, in pertinent part:

> When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits…820 ILCS 305/ 8(d)1.

TPD is an interim benefit akin to TTD and not payable after reaching MMI. In the present case, Petitioner reached MMI on 10/19/17, and returned to suitable employment on 2/28/18. Thus, his entitlement to this temporary benefit ceased.

I agree that Petitioner is entitled to wage differential benefits under §8(d)1. However, the §8(d)1 benefits should commence when he returned to suitable employment on 2/28/18. The Appellate Court addressed this in the case *Albrecht v. Industrial Comm'n,* 271 Ill.App.3d 756, 648 N.E 2d 923, 1995 Ill. App. LEXIS 148 (1992.) A professional football player was awarded wage differential benefits under §8(d)1 from the date he resumed suitable employment. The Court stated, in part:

> As stated previously, section 8(d)1 provides that awards thereunder are to be based on the difference between the "average amount" the employee would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of injury and the "average amount" he is earning or is able to earn in some suitable employment after his injury…
>
> ***We conclude that professional football players are skilled workers contemplated under the statute and that any shortened work expectancy in claimant's career would not preclude him from a wage-loss differential award under section 8(d)(1) beginning in 1983 when he started his travel business.
>
> ***The evidence indicates that claimant's earnings were approximately $80,000 in 1983, $80,000 in 1984, $87,000 in 1985, and $36,000 in 1986. These amounts are considerably less than claimant's salary of $130,000 for his final season with the Bears in 1982. The evidence clearly shows an impairment in claimant's earning capacity after his injury in 1982. Claimant's earnings in the years after his injury did not even come close to his final 1982 salary with the Bears.***We conclude that claimant has shown an impairment in his earning capacity and is eligible for wage-loss benefits under section 8(d)1. The calculation of claimant's wage-loss differential award is to be determined from 1983 when he began his business and not the date of the 1988 hearing.

See also *Payetta v. Indus. Comm'n (Graber Concrete Pipe Co.)*, 339 Ill. App. 3d 718, 721, 791 N.E.2d 682, 683, 2003 Ill. App. LEXIS 762, *6, 274 Ill. Dec. 590, (the commencement of wage differential payments is determined by when the petitioner becomes "partially

incapacitated", and the date when it could first be said that petitioner was "partially incapacitated" is the first date of his new employment.)

Here, it is undisputed Petitioner's condition had stabilized as of 10/17/17 per the FCE. Petitioner was awarded maintenance benefits from 10/20/17 to 2/27/18, while he obtained suitable employment. He began working at Tony's Finer Foods on 2/28/2018, and then secured a job at McDonald's. Because he was no longer temporarily disabled, partially or totally, and his work-related condition had reached a state of permanency, he was no longer entitled to TPD benefits. The wage differential benefit should have been awarded when he returned to work. The majority's opinion awarding the wage loss differential benefit beginning on the date of hearing has no basis in fact or law as it was neither the MMI date nor the return to work date. For these reasons, I would award the wage differential benefit commencing on the date Petitioner returned to work.

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0191

GARCIA, FILIBERTO
Employee/Petitioner

Case# **14WC041181**

CITY OF CHICAGO
Employer/Respondent

On 1/4/2019, 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 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0494 JOSEPH J SPINGOLA LTD
1314 KENSINGTON
SUITE 3843
OAK BROOK, IL 60522-7133

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Filiberto Garcia
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 14 WC 41181

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **12/14/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 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 right knee, right hip and lower back conditions of ill-being *are* causally related to the accident.

In the year preceding the injury, Petitioner earned $**77,569.75**; the average weekly wage was $**1,491.73**.

On the date of accident, Petitioner was **46** 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 $**159,268.48** for TTD, $**0** for TPD, $**47,737.92** for maintenance, and $**0** for other benefits.

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

ORDER

Medical benefits
Respondent shall pay reasonable and necessary outstanding prescription costs to ADCO (PX 10), as provided in Section 8(a) of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $994.49/week for 156 6/7 weeks, commencing 10/17/14 through 10/19/17 (the last date of treatment by Dr. Maday, per PX 6), as provided in Section 8(b) of the Act.

Maintenance
Respondent shall pay Petitioner maintenance benefits of $994.49/week for 18 5/7 weeks, commencing 10/20/17 through 2/27/18, as provided in Section 8(a) of the Act.

Temporary Partial Disability
Respondent shall pay Petitioner temporary partial disability benefits of $867.03/week for 41 3/7 weeks, commencing 2/28/18 through 12/14/18, as provided in Section 8(a) of the Act.

Wage differential
For the reasons set forth in the attached decision, the Arbitrator views Petitioner's average earnings at McDonald's between July 2, 2018 and December 2, 2018 (PX 11) as the true measure of his employability and earning capacity. Respondent shall pay Petitioner permanent partial disability benefits, commencing 12/15/18, of $982.43/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

1/4/19
Date

JAN 4 - 2019

21IWCC0191

Filiberto Garcia v. City of Chicago
14 WC 41181

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on October 16, 2014, while working as a concrete laborer for Respondent. Petitioner was off work for a substantial period following the accident. Two valid functional capacity evaluations, performed in 2015 and 2016, placed him at a medium physical demand level. Respondent did not provide him with accommodated duty at this level. He ultimately returned to work, in late February 2018, but not for Respondent. As of the hearing, he was working at a McDonald's restaurant, earning varying amounts per week, depending on the hours he was needed. The parties agree Petitioner was entitled to weekly benefits after he returned to work but they disagree as to the nature of those benefits. The disputed issues include causal connection, medical expenses, temporary total disability, maintenance, temporary partial disability, credit and nature and extent, with Petitioner claiming wage differential benefits under Section 8(d)1.

Arbitrator's Findings of Fact

Petitioner did not utilize an interpreter while testifying. He had difficulty responding to some of the attorneys' questions.

Petitioner testified he currently works for McDonald's. He previously worked as a concrete laborer for Respondent for fourteen years. His job for Respondent involved repairing sidewalks and driveways. He removed old concrete and sometimes operated a bobcat. He frequently worked in a kneeling position.

Petitioner testified he was injured on October 16, 2014, while using a 2' by 6' to carry three tiles used in disability ramps. It was raining and the surface he was walking on was wet. A big hole, left behind by a grader, was there. He slipped, striking his right knee against a curb.

An accident report completed on October 17, 2014, sets forth the following description of the injury:

> "Right knee and middle of back. Slipped on dirt and mud gave way. Putting in tiles with 2 x 6 the way we were taught."

PX 7.

Petitioner testified he did not resume working after the accident. At Respondent's direction, he went to MercyWorks, an occupational medicine facility. He complained of right knee and back pain at this facility. He saw Dr. Diadula and underwent right knee X-rays, which were negative. PX 1, p. 58. He subsequently underwent a right knee MRI. The MRI report is not in evidence.

On November 19, 2014, Petitioner saw Dr. Maday, an orthopedic surgeon affiliated with Midland Orthopedic Associates. In his note, Dr. Maday acknowledged a referral from Dr. Diadula. He recorded a consistent history of the work accident and subsequent care. He noted that Petitioner underwent an MRI "which revealed an under surface tear of the posterior horn of the lateral meniscus with a mild to moderate joint effusion." He indicated that Petitioner was still experiencing right knee instability, locking, catching and popping despite rest, ice applications and home exercises.

On initial right knee examination, Dr. Maday noted an effusion, minimal medial joint line tenderness, 2 to 3+ lateral joint line tenderness, positive McMurray's testing, negative Lachman and drawer testing and no instability with varus or valgus stressing.

Dr. Maday found a causal relationship between the twisting mechanism of injury described by Petitioner and the meniscal tear. He recommended arthroscopic surgery. He did not believe that therapy or an injection would be helpful. He directed Petitioner to remain off work. PX 1, p. 5.

Petitioner returned to Dr. Maday on January 7, 2015. He reported having obtained authorization for the surgery. The doctor noted he was still symptomatic and using a cane. PX 1, p. 6.

Dr. Maday operated on Petitioner's right knee on January 19, 2015, performing an arthroscopy and partial lateral meniscectomy. In his operative report, he noted that "the lateral meniscus revealed a complex tear of the posterior horn with a large flap tear and what appeared to be a discoid meniscus as well as a horizontal split tear that extended from the posterior to the anterior horn with multiple radial tears." He also noted areas of Grade 2 chondrosis in the lateral tibial plateau. He described the medial meniscus and anterior and posterior cruciate ligaments as intact. PX 1, pp. 77-78.

At the first post-operative visit, on January 28, 2015, Dr. Maday noted minimal complaints and a range of motion from 10 to 80 degrees. He prescribed physical therapy and Norco. He directed Petitioner to remain off work and return in three to four weeks. PX 1, p. 7.

Petitioner began a course of physical therapy at NovaCare on February 9, 2015. The evaluating therapist, Tod Miner, PT, noted complaints of right knee stiffness, weakness and pain, along with an inability to squat or kneel. PX 1, p. 86.

Petitioner returned to Dr. Maday on February 25, 2015 and complained of increased pain over the lateral aspect of the right knee. The doctor noted tenderness over the iliotibial [IT] band and minimal swelling on re-examination. After noting that Petitioner did not want to take any oral anti-inflammatory medication, he prescribed Voltaren gel and additional therapy. He continued to keep Petitioner off work. PX 1, p. 8.

Petitioner continued attending therapy at NovaCare thereafter.

On March 11, 2015, Dr. Maday noted reduced right knee flexion and exquisite tenderness over the IT band on re-examination. He also noted that Petitioner had significant difficulty stepping up onto a step. He recommended additional therapy and continued to keep Petitioner off work. PX 1, p. 9.

Dr. Maday injected Petitioner's right knee at the next visit, on April 15, 2015. He noted mild quadriceps atrophy, along with continued IT band tenderness, on that date. PX 1, p. 10.

On May 6, 2015, Dr. Maday noted complaints of numbness and tingling in the upper leg and peroneal muscles. He prescribed an EMG to see whether there were any right leg deficits stemming from a possible low back situation. He continued to keep Petitioner off work. PX 1, p. 12.

On May 13, 2015, Petitioner's therapist noted that Petitioner was unable to start work conditioning due to low back pain. PX 1, pp. 96-97.

The EMG, performed by Dr. Shah, was essentially normal. PX 1, p. 61.

On May 27, 2015, Dr. Maday noted a complaint of persistent right leg weakness. He recommended that Petitioner stay off work and progress to work conditioning. PX 1, p. 13.

A work conditioning note dated June 11, 2015 reflects that Petitioner reported right knee improvement but complained of low back pain with lifting. PX 1, pp. 100-101.

On June 17, 2015, Dr. Maday noted a complaint of non-radicular low back pain "which happened during the work conditioning program." On re-examination, he noted mild tenderness over the IT band. He prescribed Ultram and a Medrol Dose-Pak and directed Petitioner to continue work conditioning. PX 1, p. 14.

On July 1, 2015, Dr. Maday noted complaints of pain over the lateral aspect of the right leg. He also noted that Petitioner was experiencing occasional back pain and pain in the peroneal musculature. He prescribed Flexeril and directed Petitioner to complete work conditioning and undergo a functional capacity evaluation. PX 1, p. 15.

Petitioner underwent a functional capacity evaluation at NovaCare on July 15, 2015. The evaluator, Tod Miner, PT, described Petitioner as demonstrating "consistent performance throughout testing." He described the evaluation results as an accurate representation of Petitioner's abilities. He found Petitioner to be functioning at a medium physical demand level. Based on a job description provided by Respondent, he found that Petitioner did not meet the very heavy physical demands of his cement worker occupation. PX 8. He noted that several of Petitioner's functional limitations were due to complaints of low back and right hip pain. PX 1, p. 65.

On July 29, 2015, Dr. Maday reviewed the functional capacity evaluation with Petitioner. He noted that Petitioner's limitations "were primarily due to low back pain and right hip pain." He indicated that, while Petitioner's back symptoms were noted at the time of the accident, they had not been addressed. He recommended that Petitioner see his associate, Dr. Strugala. PX 1, p. 17.

Petitioner first saw Dr. Strugala on September 17, 2015. The doctor recorded a history of the work accident and subsequent right knee treatment. He noted complaints of low back pain radiating into the right leg along with intermittent right leg paresthesias and pain extending over the posterior aspect of the right thigh to the posterior aspect of the lower leg. He described Petitioner as walking without assistance. On examination, he noted pain with lumbar flexion and positive straight leg raising on the right. He prescribed a lumbar spine MRI. PX 1, p. 19.

The lumbar spine MRI, performed without contrast on October 7, 2015, showed mild left foraminal narrowing at L3-L4 and L4-L5 due to early disc bulging. PX 1, pp. 59-60.

On October 9, 2015, Dr. Strugala reviewed the MRI and EMG results. He prescribed lumbar spine physical therapy, noting that the MRI did not show any significant disc herniation. PX 1, p. 21.

On January 20, 2016, Dr. Maday noted that Petitioner was still undergoing therapy per Dr. Strugala. He described Petitioner's right knee as "fairly asymptomatic," noting a full range of motion and no medial or lateral joint line tenderness. He recommended that Petitioner start work conditioning once he completed therapy. PX 1, p. 30.

On March 22, 2016, Dr. Strugala noted that Petitioner was deriving benefit from work conditioning but "still struggling with some residual pain across his lower back." He did not anticipate the need for back surgery based on the MRI. He recommended that Petitioner continue work conditioning. PX 1, p. 45.

On March 31, 2016, Petitioner returned to Dr. Strugala, after completing work conditioning. The doctor noted that Petitioner was still experiencing pain across his lower back. He recommended pain management but Petitioner declined and requested a second opinion instead. Dr. Strugala suggested that Petitioner see Dr. Lim and avoid any heavy lifting. PX 1, pp. 37, 46, 148.

On April 13, 2016, Dr. Maday noted that Petitioner had completed a work conditioning program for his back but had not undergone work conditioning for his right knee. He prescribed two weeks of work conditioning for the knee and directed Petitioner to return in three or four weeks. PX 1, p. 47.

On May 11, 2016, Petitioner returned to Dr. Maday and indicated he needed a prescription to finish the knee-related work conditioning program. The doctor offered an injection for persistent IT band complaints but Petitioner declined this option. The doctor directed Petitioner to complete work conditioning. PX 1, p. 48.

On May 18, 2016, Petitioner began a course of treatment with Dr. Lim of Midwest Orthopaedic Consultants. The doctor recorded a history of the work accident, noting that Petitioner reported twisting his lower back when he slipped in the rain while carrying three metal plates with a co-worker. He also noted a simultaneous "distracting" right injury which required surgery. He indicated that Petitioner reported experiencing right-sided lower back pain from the accident forward. He noted that, despite extensive therapy, Petitioner was still experiencing low back pain when lifting and was afraid of reinjuring himself once he resumed working.

Dr. Lim described Petitioner's gait as normal. On lumbar spine examination, he noted tenderness at the paraspinals, a normal range of motion, intact sensation and negative straight leg raising. He obtained lumbar spine X-rays, which he described as normal. He discussed his findings with Petitioner, indicating that, regardless of treatment, there was always potential for re-injury of the lumbar spine. He recommended therapy, home exercises and a functional capacity evaluation. PX 2, pp. 19-21.

Petitioner saw Dr. Maday again on June 1, 2016. The doctor noted that the therapists had recommended two more weeks of work conditioning with an emphasis on strengthening. He kept Petitioner off work and directed him to complete the work conditioning. PX 1, p. 49.

On June 15, 2016, Dr. Lim prescribed additional work conditioning, noting that Petitioner remained symptomatic but "really wants to get back to work." PX 2, pp. 17-18.

On July 13, 2016, Dr. Lim noted no improvement. He prescribed Flexeril, Ibuprofen and a lumbar corset. PX 2, pp. 14-15.

Petitioner returned to Dr. Maday on July 20, 2016 and reported having seen another physician. Petitioner again complained of radicular type symptoms. On right knee re-examination, Dr. Maday noted a full range of motion, tenderness along the IT band and mild quadriceps atrophy. He recommended that Petitioner return in six weeks. PX 1, pp. 44, 51.

On August 17, 2016, Dr. Lim noted ongoing complaints. He prescribed Tramadol and a repeat lumbar spine MRI. PX 2, pp. 12-13. Petitioner underwent this study the same day, with the radiologist noting multi-level spinal and neural foraminal stenosis with superimposed degenerative changes. PX 2, pp. 22-23.

On September 7, 2016, Dr. Maday noted persistent right leg and back pain. He provided Petitioner with a patellar strap and recommended home exercises. PX 1, p. 43.

On October 5, 2016, Dr. Lim noted that Petitioner was no better. He refilled the Tramadol and suggested pain management and a functional capacity evaluation. PX 2, pp. 10-11.

On October 20, 2016, Petitioner underwent another functional capacity evaluation at NovaCare. The evaluator, Tod Miner, PT, noted consistent performance. He described the results as an accurate representation of Petitioner's abilities. He again found Petitioner capable of medium physical demand level activity. PX 2, pp. 27-50. PX 3.

On November 9, 2016, Dr. Maday noted ongoing complaints relative to the right knee and IT band. He recommended continued medication. PX 1, p. 42.

On November 23, 2016, Dr. Lim discussed the functional capacity evaluation results with Petitioner. He discouraged surgery but told Petitioner "that most likely this problem progresses [and] he will require surgical intervention in the future." He told Petitioner he could attempt to return to work with restrictions. PX 2, pp. 8-9.

On December 21, 2016, Dr. Maday noted that Petitioner was still having pain "in the right knee in the patellar tendon region, IT band area and posterior popliteal fossa region in the gastrocnemius area." On right knee examination, he noted a full range of motion, tenderness over the patellar tendon and IT band, tenderness in the popliteal fossa, negative Lachman and drawer testing and no instability. He continued the restrictions and medication and prescribed a TENS unit. PX 1, p. 57.

The last treatment note in evidence is Dr. Maday's note of February 22, 2017. The doctor noted that Petitioner was still complaining of pain over the anterior aspect of the knee, the IT band and the patellar tendon. He also noted that Petitioner "did not get approval for PRP injection to the affected area." On right knee re-examination, he noted tenderness over the IT band, patellar tendon and anterior aspect of the knee. He also noted minimal quadriceps atrophy, negative Lachman and drawer testing and no instability with stress testing. He indicated he did not have the most recent functional capacity evaluation report but would "most likely" impose permanent restrictions. He indicated that Petitioner planned to supply the report to him. He directed Petitioner to follow up as needed. PX 10.

At the request of his attorney, Petitioner underwent an examination by Dr. Gross on May 24, 2017. In his report of the same date, the doctor recorded a history of the work accident, subsequent treatment and permanent work restrictions. He noted complaints of right knee pain and weakness, low back pain, especially with bending, lifting and climbing, and bilateral leg numbness. On right knee examination, he noted swelling around the right patella and into the right popliteal area, atrophy of the right calf and thigh as compared with the left, tenderness in the medial joint line, marked tenderness of the lateral collateral ligament, no obvious crepitus and 4/5 quadriceps strength, compared to 5/5 on the left. On lumbar spine and hip examination, he noted tenderness bilaterally in the paraspinal muscles, worse on the right, tenderness of the sacroiliac joints bilaterally, markedly worse on the right, limited

abduction and adduction of the right hip, straight leg raising to 45 degrees on the right and 70 degrees on the left, with normal being 80, and hypersensitivity on the lateral right leg and the dorsum of the right foot. He indicated that, while Petitioner was not given a diagnosis related to his right hip, his examination findings were "severe enough to warrant a separate diagnosis." He found Petitioner to have a major loss of use of the right leg and the man as a whole. He indicated that Petitioner could not resume working as a laborer, based on the functional capacity evaluation. He provided AMA Guides impairment ratings of 1% whole person impairment for the right knee, 3% whole person impairment for the iliotibial band tendonitis and 12% whole person impairment for the spinal stenosis. PX 4.

At the request of his attorney, Petitioner met with Steven Blumenthal, MS, CRC, a certified vocational counselor, on August 17, 2017, for purposes of an interview and testing. In his report of August 20, 2017, Blumenthal described Petitioner as cooperative throughout the interview. He indicated he could communicate in English with Petitioner but that Petitioner's English vocabulary was limited and directions needed to be provided at a basic level. He noted that Petitioner reported having a limited ability to read and write English.

Blumenthal indicated that Petitioner is a 49-year-old United States citizen who has no arrest history and holds a valid Class D Illinois driver's license. He noted that Petitioner had last seen Dr. Maday on August 2, 2017 [no notes subsequent to February 22, 2017 are in evidence] and had not secured authorization for further injections and a TENS unit recommended by the doctor. He indicated that Petitioner rated his low back/right leg pain at 5-6/10, increasing to 7-8/10 with activity. He noted that Petitioner had not yet started a job search.

Blumenthal noted that Petitioner attended nine years of school in his native Mexico, obtained his GED seventeen or eighteen years earlier and attended ESL classes in Aurora twenty-nine years earlier. He also noted that Petitioner reported attending computer programming classes at St. Augustine College but dropping out after two months because he did not know how to type. He indicated that Petitioner does not own a computer and does not know how to use one.

Blumenthal noted that Petitioner began working as a concrete laborer for Respondent in October 2000 and is a member of Local 1001. He described Petitioner as previously working as a porter and custodian for Chicago Public Schools (1994-2000) and as a bus boy at a snack bar at O'Hare Airport (1990-1994). He indicated that Petitioner reported receiving workers' compensation and pension benefits and had not retired or applied for SSDI benefits.

Blumenthal administered various tests to Petitioner, including the Wide Range Achievement Test and BETA test. He concluded that Petitioner "is not a literate reader of English and is unable to read sentences and paragraphs in English on a literate basis." He also determined that Petitioner can perform basic addition, subtraction and multiplication but experienced difficulty with higher level arithmetic. He noted a BETA IQ score of 72. He described Petitioner as scoring in the "very low to low average range of nonverbal problem solving ability." He indicated that this level of performance is associated with jobs that are

structured and repetitive in nature. He identified sales clerk, cashier II, assembler, car wash attendant and cafeteria attendant as some of the jobs Petitioner could perform. He identified the hourly wage for these jobs as ranging between $11.00 (minimum wage in Chicago) and $12.85. PX 5.

At Respondent's request, Petitioner met with Diamond Warren, MS, CRC, a certified vocational counselor affiliated with MedVoc Rehabilitation, on November 27, 2017. In her report of November 28, 2017, Warren indicated she reviewed the functional capacity evaluation of November 20, 2016, a note from Dr. Maday dated October 19, 2017 and a concrete laborer job description prior to meeting with Petitioner. Warren indicated that, on October 19, 2017, Dr. Maday released Petitioner to work within the parameters of the October 19, 2016 functional capacity evaluation. [As noted earlier, the last Dr. Maday note in evidence is dated February 22, 2017.]

Warren described Petitioner as "primarily speaking Spanish." She went on to state that Petitioner was able to speak to her in English but that she and Petitioner's counsel "needed to further explain some questions so [Petitioner] could understand them." She noted that Petitioner reported having difficulty reading and writing in English. She indicated that Petitioner owned a smart phone but used it in Spanish. She also noted that Petitioner lacked typing skills and denied owning or being able to use a computer.

The occupational and educational history documented by Warren is very similar to that documented by Blumenthal. Warren noted that Petitioner's concrete laborer job for Respondent "is considered very heavy in physical demand level and unskilled in nature" based on the Dictionary of Occupational Titles.

Warren noted that Petitioner reported looking for work but was unable to provide any job search documentation. Warren indicated that Petitioner was particularly interested in working as an automobile parts delivery driver as he felt he could do this job within his restrictions. Warren noted that Petitioner reported telling prospective employers he was looking for light duty and not being given applications or interview appointments.

Warren found Petitioner to be a "good candidate for job placement services" and specifically a candidate for positions such as warehouse worker, laundry worker and cleaner. She did not indicate any projected earnings for these positions. She indicated that, if Respondent retained MedVoc's services, MedVoc would help Petitioner create a resume and cover letter and instruct Petitioner on job seeking skills and interviewing techniques. She recommended that Petitioner simultaneously enroll in ESL [English as a Second Language] classes at his local community college. PX 6.

Petitioner testified he looked for work on his own and initially found a job at Tony's Finer Foods, a grocery store. He started working in the produce department at Tony's on February 28, 2018. His job consisted of stocking vegetables and fruits and cleaning tables. He earned $11.00 per hour. Paycheck stubs in PX 11 reflect Petitioner worked ten hours between

February 28, 2018 and March 6, 2018 and five hours between March 14, 2018 and March 20, 2018.

Petitioner testified he left Tony's Finer Foods and began working at a McDonald's on March 26, 2018. His hourly rate was initially $11.00 but in July 2018 the rate was increased to $12.00. He is a cashier. His duties include taking orders, making sodas, coffees and desserts, putting foot on counters and sometimes retrieving fries. His schedule varies from day to day, depending on how busy the restaurant is. He never works 40 hours per week. He reports to work at a designated time but his supervisor sends him home early when business is slow. His paychecks vary in amount.

Petitioner testified he continues to experience pain in his right knee and back. He also experiences leg numbness, especially with stair usage. It is difficult for him to kneel or sit. His pain increases with extended walking. Each day is different, pain-wise. He typically feels better with rest. Some relatives live on the third floor. His right knee pain increases when he climbs stairs to visit them. He takes between one and three Ibuprofens per day on a near daily basis.

Under cross-examination, Petitioner testified the Ibuprofen he takes is over the counter. He injured his hip in the accident but the hip was "not accepted." He acknowledged that the accident report does not mention the hip. He is not subject to any restrictions with respect to how many hours he can work per week. He is currently working part-time and looking for another part-time job. He is also looking for full-time work at some place other than McDonald's. His paychecks show he is working about 32 hours every two weeks. He spends about 20 hours each week looking for work. When he looks for work, he goes in person. He has looked at Home Depot, Menard's, a produce store, O'Reilly Auto Parts on Addison and other McDonald's restaurants. He did not bring copies of his job applications with him to the hearing. He has not sustained any reinjuries since the work accident. He has been employed by Respondent for eighteen years. He remains an employee of Respondent. He has not applied for light duty with Respondent. He has no ability to check Respondent's website and no relatives who could help him check it. His children use computers and could help him but he has not asked them. He went to Room 101 at City Hall about a month before the hearing to look at job postings.

On redirect, Petitioner testified he asked Respondent for vocational assistance but Respondent has not communicated with him. He received a packet of ADA-related material from "Roshanna" of Respondent about four weeks before the hearing. He spoke with "Roshanna" in the last couple of weeks.

Under re-cross, Petitioner testified "Roshanna" did not mention the upcoming hearing. He did not complete the ADA paperwork.

Respondent did not call any witnesses. Respondent offered into evidence a print-out of the weekly benefits and medical expenses it has paid. (RX 1-2). RX 1 reflects that Respondent paid benefits characterized as temporary total disability (at the rate of $1,989.08 every two

weeks) from October 17, 2014 through October 27, 2017 and from September 1, 2018 through September 14, 2018 and "maintenance" at the same rate from October 28, 2017 through October 12, 2018 (with the exception of the period of September 1, 2018 through September 14, 2018).

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise, as does the fact he secured light duty work on his own. The Arbitrator finds credible Petitioner's testimony as to his current, varying schedule at McDonald's and the efforts he has made to secure a second part-time job or an alternative full-time position.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed accident of October 16, 2014 and his claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his undisputed accident of October 16, 2014 and his current right knee, right hip and lumbar spine conditions of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident right knee or lumbar spine injuries or treatment; 2) the fact that Petitioner was able to perform a very heavy concrete laborer job (PX 8) for Respondent for fourteen years before the accident; 3) Petitioner's credible description of the mechanism of injury; 4) the consistent histories set forth in the treatment records; 5) Dr. Maday's November 19, 2014 opinion that the accident caused the meniscal tear demonstrated on MRI; 6) the functional capacity evaluation of July 15, 2015, which documents complaints of right hip and low back pain as well as right knee pain; 7) Dr. Maday's note of July 29, 2015, which describes Petitioner as "continuing" to complain of low back and right hip pain; 8) the causation opinions expressed by Dr. Gross; and 9) Petitioner's credible denial of any post-accident reinjuries.

The Arbitrator recognizes that the initial accident report of October 17, 2014 (PX 7) does not specifically mention the right hip. Regardless, by May 2015, Dr. Maday was noting significant upper right leg numbness and tingling. The therapist who performed the first functional capacity evaluation, in July 2015, noted deficits relative to the right hip and back. There is no evidence indicating Petitioner injured his right hip at any point between the accident and the spring/summer of 2015. It was logical for Dr. Maday to initially focus on the right knee, given the positive MRI.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims prescription-related expenses from Adco Billing Solutions totaling $11,756.98. PX 10. These expenses relate to Gabapentin and Flurbiprofen creams prescribed by Dr. Maday, an orthopedic surgeon to whom Petitioner was referred by MercyWorks, a provider of Respondent's selection. Dr. Maday's records reflect he prescribed these creams in

2016 and 2017 with the goal of addressing Petitioner's post-operative gastrocnemius and IT band complaints. PX 1, pp. 41, 56-57. Respondent did not offer any utilization review or other evidence questioning the need for these creams. RX 2, a print-out of medical expenses paid by Respondent, documents various payments to Adco Billing Solutions during the period in question. The print-out does not reflect any payments toward the Gabapentin.

The Arbitrator finds the claimed prescription expenses to be reasonable, necessary and causally related to Petitioner's conditions of ill-being. The Arbitrator awards the expenses, with Respondent receiving credit for the payments reflected in RX 2.

Is Petitioner entitled to temporary total disability benefits?

At the hearing, Petitioner claimed he was temporarily totally disabled from October 17, 2014 through November 23, 2016 (the date of his last visit to Dr. Lim) while Respondent claimed a longer period, from October 17, 2014 through May 24, 2017. The parties stipulated that Respondent paid $159,268.48 in temporary total disability benefits. Arb Exh 1. RX 1. [As noted previously, this stipulated amount actually includes benefits paid between September 1, 2018 and September 14, 2018, outside the claimed periods.]

The Arbitrator, having reviewed all of the available evidence, disagrees with both parties on this issue. Petitioner continued to undergo right knee treatment with Dr. Maday after his last visit to Dr. Lim on November 23, 2016. On February 22, 2017, Dr. Maday noted that Petitioner remained symptomatic and "did not get approval" for the previously recommended PRP injections. PX 10. In his report of August 20, 2017, Blumenthal noted that Petitioner had seen Dr. Maday about two weeks earlier and that Respondent had declined to authorize injections and a TENS unit prescribed by the doctor. In her report of November 28, 2017, Warren cited a note that Dr. Maday authored on October 19, 2017, releasing Petitioner to work within the parameters of the October 20, 2016 functional capacity evaluation. It appears to the Arbitrator that Petitioner's causally related conditions stabilized to the extent possible, given Respondent's refusal to authorize the additional recommended care, as of October 19, 2017. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). There is no evidence indicating Petitioner underwent additional accident-related treatment after October 19, 2017.

The Arbitrator finds that Petitioner was temporarily totally disabled from October 17, 2014 through October 19, 2017, a period of 156 6/7 weeks. In accordance with the parties' binding stipulation, Respondent is entitled to credit for the $159,268.48 in temporary total disability benefits it paid prior to trial. Arb Exh 1.

Is Petitioner entitled to additional weekly benefits?

At the hearing, Petitioner claimed he was entitled to maintenance from November 24, 2016 through February 27, 2018 and temporary partial disability benefits from February 28, 2018 (the date he began working for Tony's Finer Foods) through the hearing. Respondent claimed Petitioner was entitled to maintenance from May 25, 2017 through February 27, 2018.

Respondent disputed Petitioner's entitlement to temporary partial disability benefits and claimed credit for an overpayment, citing the payments it continued making through October 12, 2018. RX 1.

The Arbitrator has previously found that Petitioner's causally related medical condition stabilized, to the extent possible, as of October 19, 2017. The available evidence indicates that Respondent declined to authorize additional care recommended by an orthopedic surgeon to whom Petitioner was referred by MercyWorks, a provider of Respondent's selection. The evidence also reflects that Respondent declined to retain MedVoc or any similar vocational rehabilitation provider and essentially left Petitioner adrift to look for work on his own, using his limited language skills, despite Warren's recommendation of ESL classes and job search services. PX 6. The Arbitrator awards maintenance at the rate of $994.49 per week from October 20, 2017 through February 27, 2018 and temporary partial disability benefits from February 28, 2018 through the hearing of December 14, 2018. Under Section 8(a), a claimant is entitled to temporary partial disability benefits when he is working light duty on either a part- or full-time basis, earning less than he would be in the full capacity of his previous job, in a modified job provided by the employer "or in any other job that [he] is working." As of February 28, 2018, Petitioner was working part-time, earning substantially less than he did with Respondent, in a job he found on his own. Respondent was never able or willing to accommodate him. The Arbitrator adopts Petitioner's method of temporary partial disability benefit calculation. Petitioner grossed $7,914.93 from his two jobs between February 28, 2018 and the hearing. PX 11. His earnings during the same time period, based on his stipulated average weekly wage, total $61,757.62 [41.4 weeks x $1,491.73/week]. The difference is $53,842.69. Petitioner is entitled to 2/3 of that amount, or $35,895.13, per Section 8(a), which averages to $867.03 per week. The Arbitrator uses the stipulated average weekly rather than the higher "full performance" wage Petitioner would have been earning per PX 9 as a conservative measure, since PX 9 does not reflect exactly when concrete laborers in Petitioner's union began receiving $41.20 per hour. In accordance with the parties' binding stipulation, Respondent is entitled to credit for the $47,737.92 in maintenance benefits it paid. Arb Exh 1.

<u>What is the nature and extent of the injury?</u>

The Arbitrator foregoes the customary Section 8.1b permanency analysis because Petitioner seeks an award of wage differential benefits. Such benefits are potentially awardable when the claimant becomes "partially incapacitated from pursuing his usual and customary line of employment." In the instant case, two valid functional capacity evaluations placed Petitioner at a medium physical demand level, significantly below the "very heavy" physical demand level associated with his former concrete laborer job. PX 8. Respondent does not dispute the results of the evaluations. Respondent declined to authorize additional care that might have resulted in improved function. Respondent did obtain a vocational assessment but then declined to follow the recommendations of the counselor who performed the assessment. That counselor identified several potential occupations but offered no opinion as to the wages associated with those occupations. Petitioner found work on his own, initially at a grocery store and then at a McDonald's restaurant, where he started at $11.00 per hour and

later received a raise to $12.00 per hour. Both rates are within the range projected by Petitioner's retained vocational rehabilitation counselor, Steven Blumenthal. PX 5.

The Arbitrator finds that, due to his injuries, Petitioner is partially incapacitated from pursuing his usual and customary concrete laborer line of employment. The Arbitrator also finds Petitioner's current job and hourly rate to be appropriate, based on Blumenthal's opinions and noting the denial of treatment and vocational services.

The Arbitrator turns to the question of calculation. Under Section 8(d)1, wage differential benefits are equal to 66 2/3% of the difference between "the average amount which [Petitioner] would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or able to earn in some suitable employment or business after the accident." In the instant case, there is no dispute that Petitioner would currently be able to earn $1,648.00 [$41.20/hour x 40 hours] per week in the full performance of his concrete laborer duties. Respondent raised no objection to PX 9, a March 9, 2018 letter from the assistant business manager of Petitioner's union indicating a current rate of $41.20 per hour. The controversy centers on the other part of the equation. Petitioner has not worked full-time at any point since he was hired by Tony's Finer Foods in late February 2018, although no doctor has set a limit on the number of hours he can work. Respondent contends that the average amount he is "able to earn" per week is $480 [40 hours multiplied by his current $12/hour salary].

The Arbitrator interprets the statute and evidence differently. The circumstance preventing Petitioner from working full-time is economic rather than medical. He is working part-time not because he wants to but because that is the schedule available to him. There is no evidence suggesting he limited his search to part-time jobs. He credibly testified he makes himself available for an entire scheduled shift at McDonald's, his current employer, only to be sent home early at his manager's whim. During some pay periods, he has been given so few hours that the resulting wages could fairly be characterized as "occasional," as in <u>E. R. Moore Co. v. Industrial Commission</u>, 71 Ill.2d 353 (1978) and <u>Zenith Co. v. Industrial Commission</u>, 91 Ill.2d 278 (1982). In both of those cases, the Supreme Court held that occasional wages from driving a school bus [<u>Moore</u>] or operating a family-owned hot dog stand [<u>Zenith</u>] a few hours a day did not preclude awards of permanent total disability. Petitioner is seeking a more modest award of wage differential benefits. The Arbitrator has no basis for concluding that Petitioner declines shifts because he was given a raise and remains in McDonald's employment. His paycheck stubs support his testimony in that they reflect widely varying schedules. He might work only 18 hours during one two-week period and 32 the next. PX 11. He also credibly testified he has continued looking for work with the goal of either supplementing or supplanting his current variable wages. That he has not been successful is not surprising, given his restrictions, the test scores documented by Blumenthal, the language difficulties identified by both Blumenthal and Warren and the lack of any job search assistance. That he has motivation to look is abundantly clear. He first found employment, on his own, in February 2018, at which point he was still receiving weekly payments from Respondent. He stopped receiving those payments in October 2018, about two months before the hearing. RX 1.

These unusual facts distinguish this case from other cases in which workers seeking wage differential benefits have opted to work part-time or avoid certain jobs, despite the absence of medically based restrictions. [See, e.g., Durfee v. Industrial Commission, 195 Ill.App.3d 886 (5th Dist. 1990), in which the Appellate Court upheld the Commission's denial of wage differential benefits because the claimant "made a personal choice to accept a lower paying position" at a school rather than attempt to resume his prior job per his physician.] There is nothing optional about Petitioner's current situation. Using a 40-hour work week to calculate wage differential benefits in this case would amount to endorsement of Respondent's inaction rather than unjust enrichment of Petitioner. Respondent should not benefit from its failure to comply with Section 8(a).

The Arbitrator finds Petitioner's average post-raise earnings at McDonald's to be a fair measure of his current earning capacity. The Arbitrator relies on the McDonald's biweekly paychecks covering the 22-week period between July 2, 2018 and December 2, 2018 in arriving at an average. PX 11. It was as of July 2018 that McDonald's raised Petitioner's hourly wage to $12.00. Petitioner worked 20.80 hours between July 2 and July 15, 2018, 12.78 hours between July 16 and July 29, 2018, 25.75 hours between July 30 and August 12, 2018, 26.15 hours between August 13 and August 26, 2018, 39.58 hours between August 27 and September 9, 2018, 34.63 hours between September 10 and September 23, 2018, 40.32 hours between September 24, 2018 and October 7, 2018, 30.68 hours between October 8 and October 21, 2018, 38.18 hours between October 22 and November 4, 2018, 18.10 hours between November 5 and November 18, 2018 and 32.73 hours between November 19 and December 2, 2018. On average, he worked 29.06 hours every two weeks or 14.53 hours per week. His average weekly earnings were thus $174.36 ($12/hour x 14.53 hours). The Arbitrator awards wage differential benefits at the rate of $982.43 per week ($1,648.00 [$41.20 x 40 hours] minus $174.36 equals $1,473.64 divided by 2/3 equals $982.43) until Petitioner reaches the age of 67 or 5 years from the date the award becomes final, whichever is later. The rate calculated via this method does not exceed the applicable maximum.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC037944
Case Name	BUCHANAN, ALVA v. CONTINENTAL TIRE THE AMERICAS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0192
Number of Pages of Decision	17
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	Brian McGovern
Respondent Attorney	James Keefe, Jr.

DATE FILED: 4/21/2021

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

Alva Buchanan,

Petitioner,

vs. NO: 18 WC 37944

Continental Tire,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator, as set forth herein, and otherwise affirms and adopts, said decision being attached hereto and made a part hereof.

Findings of Fact

Petitioner testified that on 2/12/18 he was employed by Continental Tire (hereinafter "Respondent"). (T.8). He agreed that he suffered an undisputed injury to his left shoulder on that date while "[p]ulling a stuck liner." (T.8). He agreed that he treated at the plant medical facility until 3/19/18. (T.8). He agreed that an MRI was ordered and that he then went to Dr. Frank Lee at the Bonutti Clinic. (T.8). He agreed he underwent surgery on his left shoulder on 4/26/18 and was on light duty until the time of surgery. (T.8-9). He indicated that he missed about a month from work thereafter and that he was released to full duty work on 10/8/18. (T.9). He agreed he was placed at MMI on 11/5/18. (T.9-10).

He noted that his job for Respondent was that of millman and that the maximum amount he had to lift on the job was "[p]robably 75 to 100 pounds back there on that refiner where I was working." (T.10). He indicated that the refiner is "… where they send all the stuck rubber and the junk rubber." (T.10). He stated that he "[a]bsolutley" had to do a lot of pulling and jerking as well as overhead work, noting "[y]ou had to put the bands up over your head to run the rubber

from mill to mill." (T.11). He noted that his hourly rate of pay was $24.24 and that he recently switched jobs about three months ago because he was "[f]inding it hard to do my job with my shoulder and stuff, so I switched to an easier job to help my body because I ain't getting no younger." (T.11). He indicated that he now works as a "… process crew member in the JV truck side. That's where they put the pads, the inner liner pads and the inside of the tire together, and it goes out to the truck tire to make a truck tire." (T.11-12). He noted that the maximum amount he has to lift on this new job is probably around 25 pounds and that there is no pulling or jerking and no overhead work other than "… a little bit to stick the inner roller up real quick, and that's done, put it up on the belt." (T.12). He stated that he currently earns $23.91 per hour, which represents a pay cut. (T.12).

Petitioner stated that he is currently 52 years old. (T.13). He agreed that he plans on working at GT for a period of time into the future, noting "I got a sophomore in high school, so I will be there a while, and I would like to retire one day, but you never know with the health of my wife, either, so – she has epilepsy. She is a nurse so hopefully, she can keep working." (T.12-13). When asked whether he is concerned about making it to the time he would like to retire, Petitioner replied: "Yeah. That's why I took the other job, too, to help with my body. I mean, like I said, I ain't getting no younger. I've been there working on 31 years now, so it's definitely hard work on you that's for sure." (T.13).

Currently, Petitioner noted that "I still can't do everything I used to do. I am an avid deer hunter. I can't use my compound bow anymore. I had to have [sic] to a crossbow to hunt, so I can't do that part that I loved." (T.14). He also stated that he is having trouble sleeping, noting that he is "… a shoulder sleeper, so I sleep about two hours, flip to one shoulder, sleep about two hours, then flip to the other shoulder." (T.14-15). When asked if there was anything else he noticed about his shoulder, Petitioner replied: "[l]ike I said, just doing a lot of things I used to do, I can't really do, but I don't know it's – I mean, it's the whole body. You know, like I said, I'm no younger." (T.15).

On cross examination, Petitioner agreed that the last time he saw Dr. Lee was on 11/5/18 at which time he placed Mr. Buchanan at MMI. (T.15). He likewise agreed Dr. Lee released him to return to work in his pre-accident position as a millman. (T.16). He denied going back to any medical doctor with respect to his left shoulder since 11/5/18. (T.16). He agreed that no medical doctor has placed restrictions on him that would not allow him to do the millman position. (T.16). He agreed his change to the new position with slightly less pay was voluntary, noting it was "… to help my body because it was hard for me to do the job." (T.16). He acknowledged that in his new position he still has the opportunity to work overtime. (T.16-17). When asked if his testimony was that he sleeps on each side two hours and then switches, he responded: "[a]bout that. I don't know exactly, but I know I wake up several time[s], I flip and flop, yes." (T.17).

He denied having had any prior surgery on his right upper extremity, specifically his right shoulder. (T.17). He did note, however, that he had both elbows and both wrists operated on, and that he had another surgery on one of his elbows. (T.17). He agreed that these right upper extremity surgeries were for work-related conditions for which he received settlements. (T.17-18). He denied having any surgeries on his left shoulder before his surgery with Dr. Lee in 2018.

(T.18). He did have a prior left elbow surgery that was part of a work-related claim that was settled. (T.18).

He agreed that he's a deer hunter. (T.18). He agreed that even while he was on light duty in October of 2018 he killed a 10-point buck with a crossbow. (T.19). When asked if this buck weighed more than 100 pounds, Petitioner replied: "Oh, yeah. I didn't lift it, though." (T.19). He noted that "I didn't lift any – I don't lift deer when I am healthy. I've got two 30-year old boys that I hunt with that do that. But the cross bow, … Dr. Lee said I could cross bow hunt when I asked him, and he said absolutely, but they cock themselves. There is no pulling or nothing." (T.20). He agreed that through the end of 2018 he harvested several deer, and that in addition to using a crossbow he killed deer with a shotgun. (T.19). He indicated he shoots right-handed and that he also used a muzzle loader. (T.19-20).

He agreed that it was his understanding that Dr. Lee repaired his labrum at the time of surgery and did not address the rotator cuff. (T.20-21). He also agreed that Dr. Paletta performed an exam in order to do an impairment rating at Respondent's request. (T.20).

<u>*Testimony of Dr. George Paletta*</u> (9/4/19)

Board-certified orthopedic surgeon Dr. Paletta testified that he performed an IME at the request of Respondent on 3/20/19. (RX1, p.5). He agreed he was also provided with a number of medical records as well as some MRI films. (RX1, p.6). He noted that MRI films from March 2018 demonstrated "… some tendinopathy, which is just some age-related degenerative changes, of the rotator cuff, but no evidence of a tear of the rotator cuff, he had some arthritis of the AC joint, and there was [a] little bit of irregularity at the posterior labrum… [T]here was no evidence of an obvious tear, but just some irregularity or fraying. So, based on that MRI, it was my opinion that he had some arthritis of the AC joint, some age-related changes of the rotator cuff without a tear and a positive tear of the posterior labrum." (RX1, p.8). He noted that subsequent surgery by Dr. Lee "… documented that the rotator cuff was intact. There was no tear of that. But the labrum in the posterior … was noted to have a tear… behind the biceps tendon…" (RX1, p.9). He noted that Dr. Lee "… did a repair of that labral tear using a surgical anchor or suture anchor to implant into [the] shoulder to repair the labrum." (RX1, p.9).

Dr. Paletta noted that at the time of his exam Petitioner "… still felt some discomfort lifting heavy weights overhead and some discomfort sleeping on the surgical side." (RX1,p.10). Upon exam he noted "… minimal motion loss and some mild residual weakness of the supraspinatus." (RX1, pp.10-11). He indicated that the tendinopathy changes noted on the MRI scan were age-related, degenerative changes. (RX1, p.11).

Dr. Paletta testified "[i]t was my opinion that the surgery was reasonable. It was my opinion that the mechanism of injury would have been one that could have caused the labral tear. And, so, I felt that Dr. Lee's evaluation and treatment was reasonable and necessary as a result of the work-related condition." (RX1, p.11). He also opined that Petitioner "… did not require any work restrictions and no limitations with regard to the left shoulder." (RX1, pp.11-12). He also believed Petitioner was at MMI and that "… that would have been a reasonable determination at the time that Dr. Lee released him from care in November of 2018." (RX1, p.12).

Dr. Paletta agreed he was also asked to perform an AMA impairment rating. (RX1, p.12). In this regard, Dr. Paletta opined "… the patient had an impairment rating of four percent of the upper extremity at the level of the shoulder based on the 6th Edition AMA guidelines." (RX1, p.13). He noted Petitioner "… was just a little bit worse than the default rating, and that was based on the loss of range of motion and the mild residual weakness." (RX1, p.13). He opined "… that residual weakness was not directly related to the surgery or to the injury because there was no injury to the supraspinatus. It may have been related to the fact that he was possibly still slightly under-rehabilitated, but there was no evidence of any injury that occurred from the work incident that would account for that weakness or cause that weakness." (RX1, p.14).

On cross examination, Dr. Paletta indicated that he did the AMA impairment rating as an addendum to his report. (RX1, p.15). He indicated that the rating was "… based on the history I took from Mr. Buchanan, the physical exam findings that were noted in my report and the imaging studies that were available to me." (RX1, p.15). He agreed that means it was based on when he saw him on 3/20/19 and doesn't take into account Petitioner's medical future with regard to his left shoulder. (RX1, pp.15-16). He agreed that he did not have Petitioner complete a pain or activities of daily living questionnaire, nor did he have him complete a QuickDASH report. (RX1, p.16). He stated that Petitioner did not complete any documents related to the rating process, noting that "[a]ll of the information with respect to the rating was gathered as part of the oral history that I took from Mr. Buchanan." (RX1, p.16). He agreed AMA guides are not used to diagnose or treat conditions. (RX1, pp16-17). He likewise agreed they are not used to issue work restrictions and that they are only appropriate after the patient has reached MMI. (RX1, p.17). He also was of the opinion that the concept of "impairment" is different from the concept of "disability", and that an impairment rating under the AMA guides is not the same as a disability rating. (RX1, p.17). He agreed that the guide itself simply points out that an impairment is one of several determinants of disability, and that it does not take into account pain or other subjective complaints. (RX1, p.17). He agreed it would not pick up on a patient who had good days or bad days or if certain activities increase symptoms at a particular moment in time. (RX1, pp.17-18).

Medical Records

In an Injury Report dated 2/12/18, it was recorded that Petitioner presented with a chief complaint of left shoulder pain, and that "[e]mployee states that he was pulling on stuck liner @ Refiner #2 when he felt a pop in his shoulder… Employee states that he continued working but when he needed to start pulling over head the pain was worse. He lifts his arm only shoulder high with no pain." (PX1). Ice was applied and it was noted that the employee refused any OTC meds. (PX1). Petitioner was to return to work with no overhead work with the left arm. (PX1).

An MRI of the left shoulder performed on 3/15/18 was interpreted as revealing mild to moderate degenerative changes about the left shoulder with possible small partial thickness tears along the articular margin of the rotator cuff…" (PX2).

In a Bonutti Orthopedic Services office note dated 4/4/18, Dr. Frank Lee's staff recorded that "[p]atient here for complaints of left shoulder pain. Patient was pulling uppward [sic] on rubber that was stuck. Patient states pain is not bad as long as he keeps his arm close to body but

has alot [sic] of pain with adduction with palm up and can get just about to shoulder level and he has some pain with abduction with palm down but it is not near as bad as it is with palm down." (PX2). It was noted that x-rays of the left shoulder showed type II acromion as well as moderate AC joint arthritis. (PX2). It was also noted that an MRI arthrogram revealed a possible partial cuff tear. (PX2). The impression was partial rotator cuff tear and possible superior labral tear not visible on MRI. (PX2). Petitioner was administered an injection at that time and released to no overhead or outstretched work and lifting limited to 10 pounds close to the body only. (PX2).

On 4/26/18, Petitioner underwent surgery at the hands of Dr. Lee in the form of arthroscopy, left shoulder with subacromial decompression and repair of posterior superior labrum. (PX2). The postoperative diagnosis was left shoulder posterior superior labral tear. (PX2). It was also noted in this operative report that "[t]he subscapularis and upper rotator cuff appeared to be intact." (PX2).

Petitioner returned to Dr. Lee post-operatively on 5/9/18, 6/6/18, 7/2/18, 8/8/18, 9/10/18, 10/8/18 and 11/5/18. (PX2).

In an office noted 7/2/18, Dr. Lee recorded that the patient "[t]hinks he reinjured his left shoulder. States that on 6/20/18 (8 weeks post op) he was at work training someone how to run a machine when the rubber broke and instinctively went to grab it before it fell. Shoulder hasn't felt the same since. Was given Mobic, hasn't helped much. Some deltoid and posterior shoulder pain with some triceps numbness. Has some forearm numbness on occation [sic]. Shoulder has gotten stiffer. The pain he has now is different from the pain that he had prior to sugery [sic]." (PX2). The impression was "Pt has significant internal rotation stiffness post op. Catching the falling rubber could have resulted in capsulitis. His current pain is different from his preop pain." (PX2).

In an office note dated 9/10/18, Dr. Lee recorded that "[p]atient states feels pretty good. States pulling on things bother him some. States he tried to do his regular job and does pretty good except for the pulling over his head and not sure he is ready to do that on a continuous basis. Patient goes to PT at Work Fit." (PX2). The impression was "S/P Arthroscopy, left shoulder with subacromial decompression and repair of posterior superior labrum 4-26-18. Pt does feel the preop pain has been relieved. His main constraint is related to the stiffness which is a common residual from labral repairs. He is progressing toward regular duty." (PX2). The patient was to progress to strengthening/work conditioning and given the following restrictions: limit overhead pulling, limit overhead lifting to 10 pounds, lift close to body only 20-30 pounds. (PX2).

In an office note dated 10/8/18, Dr. Lee recorded that the patient was "[c]urrently working with restrictions of 10 pounds overhead lift and 20-30 pound close to body lift. Has some posterior shoulder tightness still. Doesn't have much pain. Still doing therapy." (PX2). Petitioner was to follow up "… in 4 weeks to make sure shoulder is holding up to regular duty. If so, then he will be at MMI." (PX2).

In an office note dated 11/5/18, Dr. Lee recorded that the patient had "[n]o pain. No numbness/tingling. Work regular duty. Doing well. Wants MMI." (PX2). The impression was

"Pt continues to do well. Mild tightness in certain positions… MMI." (PX2). Petitioner was to return on an as-needed-basis. (PX2).

Conclusions of Law

The Commission notes that since the date of accident in this case, 2/12/18, occurred subsequent to the effective date of the amendment on 9/1/11, an analysis pursuant to §8.1b of the Workers' Compensation Act is required. Along these lines, the Act provides that "… [n]o single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." §8.1b(b).

With respect to factor (i), the reported level of impairment, Petitioner was examined by Dr. George Paletta who opined that "… the patient had an impairment rating of four percent of the upper extremity at the level of the shoulder based on the 6th Edition AMA guidelines." (RX1, p.13). The Commission finds that this factor is to be accorded moderate weight.

With respect to factor (ii), the occupation of the injured employee, the Commission notes that while no physician opined that Petitioner was unable to return to his prior occupation, Petitioner testified that he switched to a lesser paying job with Respondent in order to avoid the heavy lifting associated with his previous job and thus prolong his career. Thus, the Commission assigns this factor moderate weight.

With respect to factor (iii), the age of the employee at the time of the injury, the evidence shows that Petitioner was 50 years old at the time of the accident. Mr. Buchanan testified that he planned on working for a long time with the Respondent and that he was concerned about the strain on his shoulder given the strenuous nature of his work as a millman. As a result, he elected to transfer into a less demanding and lesser paying position in order to prolong his career. Thus, the Commission places moderate weight on this factor.

With respect to factor (iv), the employee's future earning capacity, the Commission notes that other than Petitioner's personal decision to take a less strenuous job with Respondent paying slightly less per hour, there is no medical evidence to show that the injury itself has affected his future earning capacity. Indeed, Petitioner was found to have reached MMI and was released to regular duty work by Dr. Lee on 11/5/18. (PX2). Thus, the Commission accords this factor lesser weight.

Finally, the Commission assigns greater weight to factor (v), evidence of disability corroborated by the treating medical records, given that said evidence necessarily reflects the nature of the injury, the scope of the treatment and extent of the recovery from a medical perspective.

In this regard, the evidence shows that following the injury Petitioner underwent an MRI of the left shoulder on 3/15/18 which was interpreted as revealing mild to moderate degenerative changes about the left shoulder with possible small partial thickness tears along the articular margin of the rotator cuff. (PX2).

In a Bonutti Orthopedic Services office note dated 4/4/18, Dr. Lee noted that x-rays of the left shoulder showed type II acromion as well as moderate AC joint arthritis. (PX2). It was also noted that an MRI arthrogram revealed a possible partial cuff tear. (PX2). The impression was partial rotator cuff tear and possible superior labral tear not visible on MRI. (PX2). Petitioner was administered an injection at that time and released to no overhead or outstretched work and lifting limited to 10 pounds close to the body only. (PX2).

On 4/26/18, Petitioner underwent surgery at the hands of Dr. Lee in the form of arthroscopy, left shoulder with subacromial decompression and repair of posterior superior labrum. (PX2). The postoperative diagnosis was left shoulder posterior superior labral tear. (PX2). It was also noted in this operative report that "[t]he subscapularis and upper rotator cuff appeared to be intact." (PX2).

In an office note dated 10/8/18, Dr. Lee recorded that the patient was "[c]urrently working with restrictions of 10 pounds overhead lift and 20-30 pound close to body lift. Has some posterior shoulder tightness still. Doesn't have much pain. Still doing therapy." (PX2). Petitioner was to follow up "… in 4 weeks to make sure shoulder is holding up to regular duty. If so, then he will be at MMI." (PX2).

In an office note dated 11/5/18, Dr. Lee recorded that the patient had "[n]o pain. No numbness/tingling. Work regular duty. Doing well. Wants MMI." (PX2). The impression was "Pt continues to do well. Mild tightness in certain positions… MMI." (PX2). Petitioner was to return on an as-needed-basis. (PX2).

Currently, Petitioner noted that "I still can't do everything I used to do. I am an avid deer hunter. I can't use my compound bow anymore. I had to have [sic] to a crossbow to hunt, so I can't do that part that I loved." (T.14). He also stated that he is having trouble sleeping, noting that he is "… a shoulder sleeper, so I sleep about two hours, flip to one shoulder, sleep about two hours, then flip to the other shoulder." (T.14-15). When asked if there was anything else he noticed about his shoulder, Petitioner replied: "[l]ike I said, just doing a lot of things I used to do, I can't really do, but I don't know it's – I mean, it's the whole body. You know, like I said, I'm no younger." (T.15).

Respondent's IME, Dr. Paletta opined that "… at the time I saw him (on 3/20/19)… [Petitioner] did not require any work restrictions and [had] no limitations with regard to the left shoulder." (RX1, pp.11-12). He also believed Petitioner was at MMI and that "… that would have been a reasonable determination at the time that Dr. Lee released him from care in November of 2018." (RX1, p.12).

Based on the above, and the record taken as a whole, the Commission modifies the Arbitrator's award to find that as a result of the accident Petitioner suffered permanent partial disability to the extent of 10% person-as-a-whole pursuant to §8(d)2 of the Act. The evidence shows that despite Petitioner's personal decision to take a less strenuous and lesser paying position with Respondent, Mr. Buchanan underwent successful labral repair surgery, missed about a month of work, and was eventually released without restrictions to full duty work. Thus, the Commission modifies the permanent partial disability award from 12% to 10% person-as-a-

whole pursuant to §8(d)2 of the Act.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/13/20 is hereby modified, as set forth herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $671.86 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained to his left shoulder caused permanent partial disability to the extent of 10% person-as-a-whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: **4/21/2021**

o: 3/9/21
TJT: pmo
51

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

/s/ *Maria E. Portela*

____

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0192
NOTICE OF ARBITRATOR DECISION

BUCHANAN, ALVA Case# **18WC037944**
Employee/Petitioner

CONTINENTAL TIRE THE AMERICAS LLC
Employer/Respondent

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 1.52% 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:

0246 HANAGAN & McGOVERN PC
BRIAN T McGOVERN
123 S 10TH ST SUITE 601
MOUNT VERNON, IL 62864-4029

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF **Mt. Vernon**)

- [ ] 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

ALVA BUCHANAN
Employee/Petitioner

Case # **18** WC **037944**

v.

Consolidated cases: ____

CONTINENTAL TIRE THE AMERICAS, LLC
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **10/10/2019**. By stipulation, the parties agree:

On the date of accident, **02/12/2018**, 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 $**58,228.04**, and the average weekly wage was $**1,119.77**.

At the time of injury, Petitioner was **50** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $**2,986.08** for TTD, $**0** for TPD, $**0** for maintenance, and $**18,812.08** for other benefits, for a total credit of $**21,798.16**.

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.

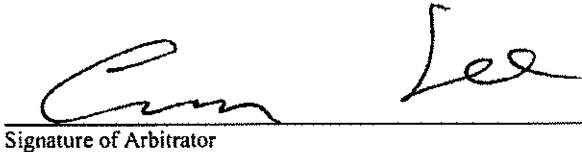
ORDER

Respondent shall pay Petitioner the sum of **$671.86**/week for a further period of **60** weeks , as provided in Section **8(d)2** of the Act, because the injuries sustained caused **12% loss on a person as a whole basis**.

Respondent shall pay Petitioner compensation that has accrued from **11/05/2018** through **present**, and shall pay the remainder of the award, if any, in weekly payments. The Respondent shall be given a credit of $18,812.08 for PPD benefits paid.

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

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



Signature of Arbitrator

1/10/20

Date

JAN 1 3 2020

FINDINGS OF FACT

On February 12, 2018, the Petitioner was employed with the Respondent. On that date, he was pulling on a tire liner when he felt pain in his left shoulder. He treated with physical therapy at the Respondent's plant until March 19, 2018. He complained of pain, pain with overhead, and reaching outward. The plant's medical provider ordered an MRI with contrast that was done on March 15, 2018.

The MRI noted moderately severe arthrosis at the acromioclavicular joint and a possible rotator cuff tear. The Petitioner was referred to Dr. Frank Lee of Bonutti Clinic, who also suspected a rotator cuff tear.

Dr. Lee performed surgery on the Petitioner's left shoulder on April 26, 2018.

The operative report says the posterior superior labrum was red and torn, but the rotator cuff and biceps were intact. Dr. Lee fixed and anchored the labrum tear and debrided the labrum's attachment on the glenoid as well. The Petitioner's shoulder also showed significant bursitis with redness and thickened tissue in the subacromial space. Dr. Lee was "unable to prove any unstable tears" of the rotator cuff. Dr. Lee also debrided and released the Petitioner's thickened coracoacromial ligament, and he finished with an acromioplasty.

The Petitioner remained completed off work for four weeks until May 23, 2019, when the Respondent accommodated his work restrictions. The Petitioner was released to full duty by Dr. Lee effective October 15, 2018, and then placed at MMI at his final visit of November 5, 2018.

The Petitioner testified that he did undergo an impairment rating with Dr. George Paletta.

He testified that at the time of the injury he was employed as a millman in mixing. He testified the job requires him to lift 75 pounds, involved frequent pulling/jerking, and overhead work. His hourly rate was $24.24 per hour.

He testified he recently changed jobs to a process crew member because his left shoulder was not allowing him to do his old job as well and he is not getting any younger. In this job, his maximum lift is 25 pounds and requires no pulling/jerking or overhead work. This new job pays $23.91 per hour.

He testified he was 52 years old at the time of the hearing, has worked at the Respondent for 31 years, and plans on working at the Respondent for a long time in the future because he has a son who is a sophomore in high school and a wife who has epilepsy. He is concerned whether he will be able to work as long as he wants to because the work at Respondent is hard; that is why he took the new, less strenuous job.

H testified he can no longer do everything he used to be able to do with the left shoulder; e.g., he had to switch to a cross bow to hunt from a compound bow, and he has trouble sleeping. He testified he sleeps on the left shoulder for two hours and flips to the right.

On cross-examination, he testified the old job was harder for him to do following the injury and surgery. He admitted he was released to full duty with no restrictions, he still works overtime, still hunts, and voluntarily changed jobs. He testified he does not use a compound bow anymore, only a crossbow, because they cock themselves, there is no pulley, but still uses a shotgun and a muzzleloader on his ride side. He admitted to recently felling a 10-point buck deer that definitely weighed over 100 pounds, but he does not lift the deer. He hunts with his two 30-year old sons that haul the deer.

The Petitioner testified he had suffered prior workers' compensation injuries to his right shoulder, bilateral elbows, bilateral hands, and back, and he received settlements for those injuries.

Dr. Paletta testified the March 15, 2018 MRI of the Petitioner's left shoulder showed

tendonopathy of the rotator cuff, arthritis of the AC joint, and a tear of the posterior labrum.

He testified the Petitioner told him he was doing well except for overhead lifting and sleeping on it.

He testified the Petitioner had an impairment rating of 4 percent of the upper extremity at the level of the shoulder, based upon the 6th edition AMA guidelines.

On cross-examination, he admitted the impairment rating does not consider the medical future of the Petitioner's left shoulder. He admitted "disability" and "impairment" are not the same. He admitted the guidelines do not consider pain or any other subjective complaints.

ARBITRATOR'S CONCLUSIONS

With regard to subsection (i) of 8.1(b): ***The reported level of impairment.***

The Respondent had the Petitioner examined by Dr. George Paletta to render an impairment rating. Dr. Paletta's report and his testimony arrived at an impairment rating of 4 percent. The Arbitrator gives some weight to this factor.

With regard to subsection (ii) of 8.1(b): ***Occupation of the injured employee at the time of the accident.***

At the time of the accident, the Petitioner was a millman in the mixing department with the Respondent. He testified this job requires very heavy lifting and pulling and overhead work, which he could not do as well following the accident and surgery.

The Petitioner sought out and took a less strenuous job because of his shoulder and his desire to work for many more years with the Respondent. The Arbitrator finds the Petitioner's work to be physically demanding. Therefore, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of 8.1(b): ***The Petitioner's age at the time of injury.***

The Petitioner was 50 years old at the time of the injury and testified he planned on working for a long time with the Respondent. He testified he was concerned about being able to work until the time he wants to retire because of his shoulder and length of time he has been working at the Respondent, which is an arduous place to work. Therefore, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of 8.1(b): ***The Petitioner's future earning capacity.***

The Petitioner testified the job he had at the time of his injury required him to lift up to 100 pounds and involved a lot of pulling and overhead work and paid $24.24 per hour.

He testified he switched to the process crew member because it is less strenuous even though it pays only $23.91 per hour. Therefore, the Arbitrator gives some weight to this factor.

With regard to subsection (v) of 8.1(b): ***Disability as corroborated by the treating medical records.***

The Arbitrator notes the Petitioner's complaints of disability and concerns about the future coupled with the treatment of left shoulder surgery set forth in the records. Therefore, the Arbitrator gives significant weight to this factor.

Based on the above the Arbitrator awards the Petitioner 12% loss of use on a MAW basis.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC018151
Case Name	LOGAN, CARMELITTA v. CHICAGO TRANSIT AUTHORITY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0193
Number of Pages of Decision	15
Decision Issued By	Maria E. Portela, Commissioner

Petitioner Attorney	James Burke
Respondent Attorney	Andrew Zasuwa

DATE FILED: 4/23/2021

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

Carmelitta Logan,

Petitioner,

vs. NO: 19WC 018151

Chicago Transit Authority,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, penalties and 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 11, 2020 is hereby affirmed and adopted.

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

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

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: 4/23/2021

MEP/ypv
o022321
049

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

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

LOGAN, CARMELITTA Case# **19WC018151**
Employee/Petitioner

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 3/11/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% 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:

2662 LAW OFFICES OF JAMES J BURKE
333 N MICHIGAN AVE
SUITE 1126
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

21IWCC0193

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)

Carmelitta Logan
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **19** WC **18151**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☒ Were the 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. X Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of the alleged accident, **June 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 not*** sustain an accident that arose out of and in the course of employment. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

Timely notice of the alleged accident ***was*** given to Respondent.

In the year preceding the injury, Petitioner earned $**73,253.96**; the average weekly wage was $**1408.73**.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**480.00** for other benefits, for a total credit of $**480.00**.

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

ORDER

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner lacked credibility and failed to establish she sustained a compensable work accident on June 4, 2019. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. 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

3/11/20
Date

ICArbDec19(b)

MAR 1 1 2020

Carmelitta Logan v. CTA
19 WC 18151

Summary of Disputed Issues

Petitioner, a longtime bus operator, testified she had no physical complaints when she started her route at 3:06 AM on June 4, 2019. She claims she injured her neck and left arm that day when she turned the bus steering wheel abruptly to the right to avoid a large pothole. She continued driving but began operating the bus one-handed, due to her symptoms. When she reached the end of the line, around 5 AM, she contacted "control," reported severe left-sided pain and requested medical treatment. She answered "no" in response to a question asking whether she had been involved in an accident. Paramedics noted a complaint of left hand pain and numbness starting two hours earlier. PX 11. Emergency Room personnel noted that Petitioner had been experiencing left shoulder and neck pain for "many months" and experienced increased symptoms on waking that morning. Neither the paramedic records nor the Emergency Room records contain any mention of the pothole-related incident Petitioner testified to. The Emergency Room physician diagnosed cervical radiculopathy and a rotator cuff strain. PX 1. Petitioner subsequently saw Dr. Turk, a chiropractor she had seen in the past, and Mohiuddin, a pain physician. She underwent therapy and injections.

Two reports completed on June 4, 2019, after the Emergency Room visit, reflect that Petitioner began experiencing left arm and neck symptoms after managing to avoid a pothole. PX 8-9. An interview record, also dated June 4, 2019, reflects that Petitioner maneuvered her bus to avoid a pothole at Ashland near Taylor and began experiencing left forearm and neck pain later, while approaching the end of the line. PX 10.

As of the hearing, Petitioner was still off work and undergoing treatment.

Respondent paid no benefits under the Act. Arb Exh 1.

The disputed issues include accident, causal connection, medical expenses, temporary total disability, penalties/fees and prospective care. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she is 56 years old. She began working as a bus operator for Respondent in April 1989. T. 10. She continued working in the same capacity thereafter, with the exception of a one-year period between 2010 and 2011. T. 11.

Petitioner testified she was assigned to the 74th Street garage as of June 4, 2019. Her bus operator duties included driving a route, picking up passengers, collecting fares and operating a lift. T. 11. She has driven both articulated and standard buses. T. 12.

Petitioner acknowledged experiencing pain and stiffness in various body parts before the accident but denied seeking any treatment for these ailments. T. 18.

Petitioner testified she felt "fine" when she woke up on June 4, 2019. T. 23. She denied reporting pain or problems to anyone at Respondent before she arrived at work that day. She checked in with a clerk before starting her route. T. 12-13. The clerk has the task of checking a driver's demeanor, to make sure he or she is not intoxicated and capable of driving. After the clerk checked her, she received a slip assigning her to a particular bus. T. 13.

Petitioner testified she was assigned to the 9 Ashland bus route as of the accident. This route starts at 74th and Ashland. It proceeds south to 95th, east to State Street, and back west before heading north to Belle Plaine. Petitioner testified she started her shift at 3:06 AM. T. 15. It was dark out. The weather was dry. T. 15. She drove a standard bus to the 95th Street Red Line station, encountering no difficulties, and then headed northbound on Ashland. She was driving on Ashland, near Taylor Street, traveling about 15 to 20 miles per hour, when she was injured. There were about ten passengers aboard the bus at that time. T. 16. She was not behind schedule. She was approaching a big pothole and wanted to avoid it. She jerked the steering wheel to the right and felt pain in the left side of her neck, her left shoulder and her left arm. T. 17-18. She shook her left hand and said "wow." She continued driving, hoping the pain would go away. Her symptoms persisted and she began driving one-handed. T. 19. She reached the end of the line, at Clark and Belle Plaine, at about 5 AM. The bus was empty at that point. T. 19-20. She called her "controller," reported experiencing severe left-sided pain and requested an ambulance. She also reported there were no passengers aboard the bus. She answered "no" in response to a question asking whether an accident had occurred. T. 20. She parked the bus and waited. T. 22.

Petitioner testified that an ambulance was the first vehicle to arrive at the scene. She told the paramedics she was experiencing severe left-sided pain. She also told them what had happened. They asked if she wanted to go to the hospital and she said "yes." The paramedics then transported her to Weiss Memorial Hospital. T. 22.

The Chicago Fire Department run sheet of June 4, 2019 reflects that paramedics arrived at West Belle Plaine and Clark at 5:18 AM and encountered Petitioner sitting upright in the driver seat of a CTA bus "in no distress." The report describes Petitioner as stating "she suddenly began having left hand pain and numbness that started 2 hours prior to EMS arrival." Petitioner denied having chest pain or shortness of breath. The report contains no mention of Petitioner steering to avoid a pothole. The word "no" appears in response to a question asking whether the symptoms were work-related. PX 11, p. 1 of 3. The paramedics placed Petitioner on a stretcher and transported her to Weiss Memorial Hospital. PX 11.

The Emergency Room records (PX 1) reflect that Petitioner arrived at the hospital at 5:44 AM via the Chicago Fire Department. A triage note reflects that Petitioner reported left arm pain and tingling. This note also reflects that "pt states she was driving when she felt 'something just wasn't right.'" PX 1. The records also contain the following clinical history:

> "Pt is a 58 yo female with pmh of hypertension presenting today due to left shoulder pain. She states she drives a CTA bus and it is difficult now for her to turn the wheel. She has been dealing with issues of lt shoulder and neck pain for many months but upon awakening it was worse. States she gets tingling when she moves her neck or arm a certain way. No focal weakness complaint or loss of bowel or bladder control. No history of trauma. Denies any cp, sob or lower extremity pain or swelling. Symptoms are better if she doesn't try and lift left arm. No other modifiers or associated ss such as fatigue, diaphoresis, nausea, vomiting, doe, etc."

The examining physician, Dr. Rome, noted a "very positive drop test" on left arm examination and tenderness to palpation of the left subacromial area. She administered a Keterolac injection and ordered an EKG and left shoulder X-rays. The EKG showed a normal sinus rhythm. The left shoulder X-rays were negative. Dr. Rome diagnosed cervical radiculopathy and a left rotator cuff strain. She prescribed Keterolac and Tramadol for pain. She recommended that Petitioner avoid using her left arm, stay off work and see her primary care physician within a day or two. T. 23. Hospital personnel placed Petitioner's left arm in an Ace wrap and sling.

The Emergency Room records also contain the following addendum note dated December 19, 2019: "Of note, this was work-related injury and pt had symptoms due to hx of driving the bus and shoulder overuse. She had come to the hospital as she later stated she was avoiding a pothole and it caused her shoulder pain." PX 1.

On direct examination, Petitioner testified she does not recall telling hospital personnel she woke up in pain on the morning of June 4, 2019. T. 23-24.

Petitioner testified that a Respondent supervisor came to the Emergency Room and drove her to the garage. T. 24.

Petitioner testified she saw Dr. Turk, a chiropractor, on June 6, 2019. She had seen Dr. Turk in the past. T. 24. She told him what had happened. He kept her off work and prescribed physical therapy. T. 24.

A handwritten note in Dr. Turk's records reflects that Petitioner reported experiencing severe neck and left shoulder/arm pain on June 4, 2019 when she "quickly turned the steering wheel to avoid a pothole" while she was operating a CTA bus. The doctor indicated he was unable to perform a complete orthopedic evaluation due to Petitioner's 8/10 pain level. He noted extreme pain with attempts at abduction along with tenderness and apparent swelling in the deltoid region. He directed Petitioner to remain off work and begin therapy. T. 25. He recommended a cervical spine MRI and indicated Petitioner might also need a left shoulder MRI. He completed an "attending doctor's statement" indicating Petitioner sustained an "on the job injury." PX 2.

On June 24, 2019, Sedgwick Claims Management sent Petitioner a letter referencing a first day of absence of June 4, 2019 and advising her that she might be eligible for short-term disability benefits. PX 12.

Petitioner testified that Dr. Turk sent her to Illinois Orthopedic Network, where she saw Dr. Mohiuddin on July 24, 2019. T. 27. The note of that date sets forth the following history:

> "This is a female patient who presents today for initial evaluation after a work-related injury that occurred on 6/4/19. She works for CTA and has worked there for 29 years. She was driving a bus on 6/4/19 and was going over a pothole and, as she was going over the pothole, the bus shook and she hyperextended her neck and felt acute pain in her neck with radiation to the left shoulder."

The doctor also noted that Petitioner denied any history of neck or left shoulder pain prior to the accident. On examination, he noted positive tenderness and hypertonicity to the cervical paraspinal musculature with radiation to the left greater than right trapezius and diffuse tenderness throughout the left shoulder, most prominent in the AC joint and left trapezius. He also documented 3/5 supraspinatus strength when compared to the right, secondary to pain.

Dr. Mohiuddin recommended that Petitioner discontinue the sling and continue attending therapy. He also prescribed a cervical spine MRI and medication. He directed Petitioner to remain off work. PX 4.

Petitioner began undergoing therapy with Dr. Horner of South Suburban Physical Therapy on July 24, 2019. Petitioner testified that Dr. Turk referred her to this facility. Dr. Horner noted that Petitioner reported feeling a pull in her left shoulder on June 4, 2019, when she grabbed the steering wheel of her bus to avoid a large pothole. Dr. Horner also noted that Petitioner complained of left hand tingling and left-sided neck pain and had been wearing a left shoulder sling since the accident. PX 6.

Petitioner continued undergoing therapy thereafter. On August 5, 2019, Dr. Horner noted that Petitioner denied improvement. PX 6.

Petitioner returned to Dr. Mohiuddin on August 8, 2019 and reported being unable to undergo the MRI due to extreme claustrophobia. Petitioner indicated she remained symptomatic. The doctor's examination findings were essentially unchanged. The doctor recommended a left shoulder MRI along with a cervical spine MRI and prescribed a sedative to help Petitioner relax during these studies. He continued to keep Petitioner off work. PX 4.

The cervical spine MRI, performed in an upright position on August 20, 2019, showed mild cervical spondylosis, minimal bulges at C2-C3, C3-C4 and C4-C5, mild to moderate stenosis of the right neural foramen due to an osteophyte complex at C5-C6 and a minimal bulge at C6-

C7. The left shoulder MRI, performed without contrast the same day, showed a tiny degenerative cyst at the superolateral subcortical region of the posterior humeral facet. The radiologist described the MRI as "otherwise unremarkable." Another left shoulder MRI, performed in coronal extension and internal rotation, showed no evidence of dislocation or impingement. The radiologist described the labrum-ligament complex as intact. PX 4.

On August 27, 2019, Dr. Horner noted that Petitioner rated her pain at 10/10. PX 6.

On August 29, 2019, Dr. Chunduri of Illinois Orthopedic Network noted ongoing 10/10 neck and left shoulder symptoms. He reviewed the MRIs, indicating they showed no significant left-sided pathology. He recommended a left upper extremity EMG and directed Petitioner to remain off work. PX 4.

The last therapy note in evidence, dated September 12, 2019, reflects that Petitioner rated her pain at 5/10 and was awaiting an EMG. PX 6.

Dr. Arayan of Illinois Orthopedic Network performed the recommended left upper extremity EMG on October 16, 2019. He found electrodiagnostic evidence of a left C6, C7 cervical spine radiculopathy. PX 4. T. 27-28.

Petitioner testified she did not return to Illinois Orthopedic Network because "they discharged [her]." T. 28.

On November 1, 2019, Petitioner saw a different pain physician, Dr. Alhaj-Hussein, at Illinois Pain Management. The doctor noted that Petitioner's symptoms started on June 4, 2019, when she "drove over a pothole" and "felt severe jerking of her neck and sharp pain in her neck." He also noted that Petitioner subsequently experienced left shoulder pain, pain traveling down her arm, numbness in her thumb and index finger, weakness in her left hand and pain in the back of the left side of her head going over her scalp. On examination, the doctor noted tenderness on deep palpation of the paraspinal area bilaterally, more pronounced on the left, tenderness on deep palpation over the left greater occipital nerve and a decreased range of neck and left shoulder motion. He recommended that Petitioner continue taking Gabapentin and undergo a C6-C7 interlaminar cervical epidural steroid injection. He directed Petitioner to remain off work. PX 7.

Dr. Alhaj-Hussein administered the recommended injection on November 18, 2019. PX 7. Petitioner testified she experienced relief for two days after this injection. T. 31.

On December 6, 2019, Dr. Alhaj-Hussein noted that Petitioner reported approximately 30% improvement following the injection but was still experiencing symptoms in her neck, left shoulder and left arm. He discussed the option of Petitioner seeing a spine surgeon but described Petitioner as "adamantly refusing to consider surgery at this point." He scheduled a second injection and directed Petitioner to remain off work. PX 7.

On January 3, 2020, Dr. Alhaj-Hussein noted that Petitioner complained of recurrence of her neck and left shoulder pain as well as finger numbness and grip weakness. The doctor again recommended a spine surgery consultation but noted that Petitioner wanted to try another injection. He continued to keep Petitioner off work. PX 7.

Dr. Alhaj-Hussein administered a second C6-C7 injection on January 13, 2020. PX 7. Petitioner testified this injection also helped for about two days. T. 31.

On January 31, 2020, Dr. Alhaj-Hussein noted that Petitioner reported 60% improvement but remained symptomatic. He also noted that Petitioner wanted to try a third injection. He directed Petitioner to remain off work. PX 7.

Petitioner testified she is scheduled to undergo a third injection on February 24, 2020. T. 31.

Petitioner testified she has limited use of her left arm and left shoulder. She deals with her symptoms by resting and taking medication. Her symptoms disturb her sleep and affect her ability to perform daily activities. T. 32.

Petitioner testified she drove a bus consistently for years before the accident. She denied having any disability in her neck, left arm or left shoulder before the accident. T. 32.

Petitioner testified that Respondent never advised her that her workers' compensation claim was denied. She "never signed a sick book." T. 33. She did not apply for disability benefits but received two disability checks back in July. She never received temporary total disability benefits. Her medical bills are unpaid. [The Arbitrator notes that CIGNA paid some of the expenses associated with the Emergency Room care. PX 1.] Dr. Turk sent disability slips to Respondent. Dr. Hussein gave disability slips to her. She kept these slips. T. 34.

Petitioner testified she initially retained attorney Kenneth Gore to represent her. Gore then referred her to attorney Dworkin. At some point, she began having difficulties with Dworkin's office. She brought a motion to discharge Dworkin. Dworkin withdrew from her case. T. 26-28.

Under cross-examination, Petitioner acknowledged completing and signing PX 8, an Injury on Duty report, after she was seen at the Emergency Room. In this report, she indicated she managed to avoid a pothole and then began experiencing tingling in her left arm. Her bus did not go down into a pothole. T. 35-37. Petitioner also acknowledged completing and signing PX 9, a "miscellaneous incident report." She completed this report at Respondent's garage, after her Emergency Room visit. She completed PX 8 and PX 9 at the same time. She was honest with the paramedics and with Emergency Room personnel. She told the Emergency Room physician and Dr. Turk what happened. She was also honest with Dr. Mohiuddin. She did not see the doctor writing anything down. She does not recall seeing Dr. Chunduri. T. 42. She was honest with the doctor who performed the EMG. T. 43. On June 4, 2019, she started her

shift at around 3 AM. She reached the end of the line at about 5 AM. She is not sure how long it takes to drive from Ashland and Taylor to the end of the line at Clark and Belle Plaine. T. 44.

On redirect, Petitioner testified she completed PX 8 at the 74th Street garage. She has no idea why the Emergency Room physician wrote that she woke up in pain on the morning of June 4, 2019. That "could be" a misinterpretation of what she told him. After the accident, she had to drive one-handed due to pain. She did not check the accuracy of the notes her doctors wrote. T. 46. The hospital was busy when she arrived. T. 46. All of her doctors have told her she was injured. T. 46-47.

In addition to the exhibits previously mentioned, Petitioner offered into evidence an unfiled petition for penalties and fees. PX 13.

Respondent did not call any witnesses or offer any documentary evidence. Respondent's attorney indicated he was relying on Petitioner's exhibits. T. 48, 62.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in her favor, credibility-wise, but the Arbitrator was unable to reconcile her testimony with her initial medical records. At the hearing, Petitioner described a very specific steering-related event, indicating she turned the wheel of her bus abruptly to the right to avoid a pothole. Neither the paramedics nor the providers at the Emergency Room noted any such event. Petitioner also testified her symptoms started immediately after she turned the wheel. The Emergency Room records reflect that Petitioner reported having neck and left shoulder symptoms "for many months" and indicated those symptoms were worse when she woke up on June 4, 2019. The accident reports of June 4, 2019 mention the steering-related event but Petitioner completed those reports after she left the Emergency Room.

Some of the subsequent histories also conflict with Petitioner's account. Petitioner specifically denied going down into the pothole but Drs. Mohiuddin and Arayan indicated she did.

Petitioner denied seeing any doctor for neck, left arm or left shoulder problems before the work accident but acknowledged having seen Dr. Turk, a chiropractor, before June 6, 2019, the first date she saw him after the accident. T. 24. No pre-accident records from Dr. Turk are in evidence.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on June 4, 2019 arising out of and in the course of her employment?

As noted above, Petitioner's detailed testimony concerning the accident is at odds with the histories documented by the paramedics and hospital personnel. The Emergency Room records would potentially support a repetitive trauma claim but Petitioner testified to a very specific event and an abrupt onset of symptoms. Petitioner's testimony is also at odds with the histories recorded by Drs. Mohiuddin and Arayan, as noted above. Petitioner denied driving over a pothole but Dr. Mohiuddin indicated she reported hyperextending her neck when the bus shook while she was going over a pothole. Dr. Arayan indicated Petitioner described the steering wheel as "jerking" when she drove over a pothole. PX 4.

The Arbitrator recognizes that, on June 4, 2019, Petitioner completed accident reports in which she stated she became symptomatic after steering to avoid a pothole. PX 8-9. Petitioner testified she completed these reports at Respondent's garage, after she left the Emergency Room. The reports appear to be an afterthought.

The Arbitrator finds that Petitioner lacked credibility and failed to establish a compensable work accident. The Arbitrator views the remaining disputed issues as moot. Compensation is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC008241
Case Name	HEREDIA, MARIA C v. PURI CORP D/B/ A DUNKIN DONUTS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0194
Number of Pages of Decision	17
Decision Issued By	Maria E. Portela, Commissioner

Petitioner Attorney	Michelle Porro
Respondent Attorney	AG CHICAGO WORKERS COMP, Alyssa Silvestri, Andrew Kriegel

DATE FILED: 4/23/2021

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF KANE	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria C. Heredia,

Petitioner,

vs. NO: 09WC 008241

Puri Corp d/b/a Dunkin Donuts and "State Treasurer
and Ex-Officio Custodian of the Injured Workers'
Benefit Fund.",

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, benefit rates, medical expenses, notice, 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.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 3, 2019 is hereby affirmed and adopted.

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

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

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

DATED: **4/21/2021**
MEP/ypv
o022321
049

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0194

HEREDIA, MARIA C Case# **09WC008241**
Employee/Petitioner

PURI CORP D/B/A DUNKIN DONUTS AND THE IWBF
Employer/Respondent

On 1/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1869 PRESBREY & ASSOCIATES
MICHELLE D PORRO
821 W GALENA BLVD
AURORA, IL 60506

1876 GRAUER & KRIEGEL
ANDREW J KRIEGEL
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6197 ASSISTANT ATTORNEY GENERAL
PATRICIA J JEMBA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Maria C. Heredia
Employee/Petitioner

Case # **09** WC **8241**

v.

Consolidated cases: **N/A**

Puri Corp. d/b/a Dunkin Donut and the IWBF
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **October 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other: **Proof of Insurance and IWBF Responsibility**

FINDINGS

On **July 18, 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 **$16,640.00**; the average weekly wage was **$320.00**.

On the date of accident, Petitioner was **47** years of age, *single* with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $213.33/week for 164 6/7 weeks, commencing December 5, 2008 through February 1, 2012, as provided in Section 8(b) of the Act.

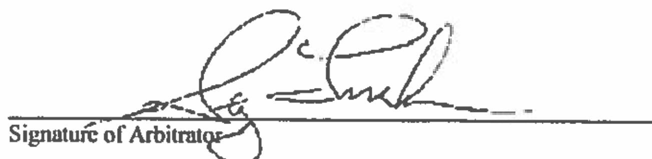
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,985.00 to Dr. Bare, $1149.00 to Hinsdale Orthopedics, $1000.00 to Dr. Neri, $34.99 to Walgreens, and $53,244.50 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $206.67/week for 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.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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



Signature of Arbitrator

December 28, 2018
Date

JAN 3 - 2019

Statement of Facts

Petitioner Maria Heredia testified in Spanish through Ms. Lourdes Soto, who interpreted the proceeding for Petitioner. Petitioner offered PX 1 from the Insurance Compliance Division stating that on July 18, 2008, Respondent Puri Corp d/b/a Dunkin Donuts was not covered by a policy of insurance based on the NCCI records. Respondent Puri Corp. d/b/a Dunkin Donuts appeared through counsel at the hearing in this matter. The Illinois Workers' Benefit Fund appeared the through the Attorney General's Office.

Petitioner testified that on July 18, 2008, she was employed as a cook at Respondent Puri Corp., d/b/a Dunkin Donuts for three years. She testified that as a cook she would take care of all the orders and help in the Subway or at the gas station which were located in the same building. Petitioner testified she was making $8.00 per hour. She worked 40 hours per week. Overtime was not included in her paychecks. It was paid separately. She testified she worked Monday through Saturday totaling 40 to 50 hours per week. Her boss would call her when he needed somebody and pick her up. PX 10 is Petitioner's pay stubs for the periods of July 14, 2008 through July 27, 2008 and July 28, 2008 through August 10, 2008. PX 11 consists of 9 cash register receipts for her cash payments for overtime that she received from her boss Dixie Patel.

On July 18, 2008< Petitioner testified that she was 47-years old. She was single. Petitioner testified that she cared for two minor grandchildren. Her daughter had just turned 18. Petitioner testified she was supporting her school. PX 14 includes the birth certificate of her daughter Elizabeth Vega Heredia born June 2, 1990. Petitioner had another daughter named Anabel who was born March 20, 1982 who had a daughter named Michelle. Petitioner testified that Michelle Ibarra Vega, born August 30, 2013, was her granddaughter and Nestor Duvanne Mejia Vega, born June 23, 1997, is her grandson by her oldest daughter Belen Vega Heredia. She testified that she sent money to him in Mexico for his support. She testified that these were her three dependents at the time of her injury (PX 14).

Petitioner testified that at 8:00 AM on July 18, 2008, she went to pick up a tray of bread and while putting it on the table, she tripped over a bag of flour, falling on her right elbow and hurting her right index finger and right hip. Petitioner testified that Dixie Patel saw the injury from the office on the camera. She testified she told her supervisor Herman. Petitioner was first seen at the emergency room at Central DuPage Hospital.

The Central DuPage Hospital records show Petitioner's emergency room visit on July 18, 2008 at 3:18 PM with a translator present. The history notes Petitioner's symptoms began one hour ago. Patient 'just' fell – no proximate cause," and "Patient slipped at work and fell onto her right shoulder and jammed index finger" (PX 8, p 160). X-rays of the right elbow, right hand and right shoulder were taken on July 18, 2008 and demonstrated no definite fracture, dislocation or bony abnormality (PX 8, p 167-169). Petitioner was discharged home and told follow-up with CDH Business Health the following Monday. She was told to take ibuprofen and provided a sling for her soft tissue injury (PX 8, p 162-165).

Petitioner saw Dr. Headley of Central DuPage Business Health on July 22, 2008 (PX 3). Petitioner's pain diagram noted right shoulder and elbow pain and pain on the back of the left hip. X-rays were taken of the right humerus and left hip/pelvis and demonstrated no fracture. The X-ray reports note the Indication was "Fell at work." Petitioner was advised to use a sling for comfort, was prescribed ibuprofen and Vicodin, and placed on restricted work with left handed work only and sit-down work (PX 3). Physical therapy was ordered on August 1, 2008. A physical therapy evaluation was performed on August 6, 2008. Petitioner's history was that she tripped over a bag of flour on the floor while carrying a tray. The diagnoses noted a right shoulder/arm

contusion, left hip strain, and right index finger contusion. Petitioner participated in physical therapy at Central DuPage Business Health through December 4, 2008 (PX 3). Dr. Headley referred Petitioner to Dr. Aaron Bare on August 15, 2008 for treatment of her shoulder.

Petitioner was seen by Dr. Bare on August 22, 2008 (PX 2). Dr. Bare notes a history of a lifting incident at work. He notes additional complaints in the right elbow and left hip which had gotten better. Dr. Bare diagnosed pain in the shoulder and adhesive capsulitis. He ordered an MRI and provided a cortisone injection to the right shoulder. He stated that the condition of the right shoulder was related to the accident. He placed Petitioner on work restrictions (PX 2). Petitioner saw Dr. Headley on August 27, 2008. He advised Petitioner of the potential long-term complications should she fail to take a more active role in the therapy for her shoulder (PX 3). The impression of the September 6, 2008 right shoulder MRI was moderately severe supraspinatus tendinosis with mild associated subacromial-subdeltoid bursitis and a 3 x 3 mm anterior supraspinatus interstitial insertional tear, without demonstrable articular or bursal surface penetration (PX 2). On September 19, 2008, Petitioner complained of continued left hip pain since the date of the injury with some progress in therapy. She reported limited to no improvement in the shoulder. Dr. Bare noted the MRI films showed supraspinatus tendinosis and no evidence of tears in the right shoulder. Inflammation was present. He recommended continued physical therapy. He stated that the hip pain was likely secondary to the lumbar spine (PX 2).

Dr. Bare provided another cortisone injection to the shoulder on October 24, 2008 (PX 2). The October 30, 2008 therapy notes mention Petitioner's continued complaints of difficulty with her job duties at Dunkin Donuts such as continuing to lift and carry trays with both hands. The therapist notes some improvement following the cortisone shot, but continued resistance and low tolerance of range of motion and gentle stretching continue (PX 3). On December 5, 2008, Petitioner reported the left hip was doing much better with essentially normal range of motion and an unremarkable straight leg raise. The right shoulder noted severe recumbent refractory adhesive capsulitis. Dr. Bare recommended referral to Dr. Mayer for the hip and potentially sciatic symptoms. For her shoulder, he recommended a closed manipulation followed by an arthroscopic lysis of adhesions followed by physical therapy. Petitioner was taken off work at that time awaiting surgical approval (PX 2).

Petitioner testified that she worked for Respondent until December 5, 2008. Respondent was not honoring her medical restrictions. She went back as a cook doing most of the same work. She would do it more slowly. She wanted the surgery recommended by Dr. Bare but could not obtain it.

Petitioner testified she sought treatment with Dr. Burra. She was seen by Dr. Burra on June 25, 2009 (PX 4). Dr. Burra notes the history of a lifting injury recorded by Dr. Bare, but Petitioner told him that she fell and developed right shoulder and upper extremity pain and left hips symptoms. She stated that the left hip pain had completely resolved. She reported no treatment since the December 5, 2008 appointment with Dr. Bare. Petitioner reported worsening symptoms with 10/10 pain, significant color changes, intermittent temperature changes and increasing stiffness. Dr. Burra notes extremely limited range of motion. He diagnosed right upper extremity pain with a very strong clinical indication of CRPS and adhesive capsulitis and flexion contracture of the elbow. Dr. Burra recommended aggressive physical therapy and scalene blocks. He notes surgical intervention may be needed in the future. He referred Petitioner to his partner, Dr. Schiffman, for further evaluation (PX 4). On July 2, 2009, Dr. Schiffman stated that there are no signs to indicate that this is a reflex sympathetic dystrophy. Petitioner had an unusual pattern consistent with a more central nervous system issue. He was unable to make sense out of this pattern developing in an injury to the upper extremity. Dr. Schiffman recommended a neurologic consultation and referred Petitioner to Dr. Neri (PX 4).

Petitioner was seen by Dr. Neri on September 3, 2009. Dr. Neri's September 11, 2009 letter to Dr. Schiffman documented that Petitioner was injured when she slipped while working at Dunkin Donuts striking her right forearm on the floor. He notes extreme weakness of the right shoulder. Attempts at motion cause severe pain. His neurological examination notes diminished pin prick from C3 to T1 on the right, diminished temperature of the right arm and dusky appearance. His impression is early RSD and probable rotator cuff injury if not brachial plexus involvement of the right arm (PX 7). He issued some prescriptions on October 7, 2009 and January 4, 2010 (PX 7). On January 25, 2010, Dr. Schiffman told Petitioner's husband that she should follow up with Dr. Burra (PX 4). On February 15, 2010, Dr. Burra stated he believed Petitioner had a manifestation of a fairly significant CPRS and that this needs to be addressed before any further intervention may be safely attempted. He provided Petitioner with Dr. Lipov for treatment of the CRPS. He also recommended aggressive physical therapy. He kept Petitioner off work (PX 4). On April 2, 2010, Dr. Burra noted no significant change. He stated that while surgical intervention is inevitable for the shoulder, the CRPS would be aggravated by surgery now. He again recommends consultation with Dr. Lipov before any further treatment for the shoulder. Petitioner is to remain off work (PX 4). Petitioner testified that she did not treat with Dr. Lipov.

Petitioner returned to Dr. Burra for follow up on January 31, 2011. He reviewed Dr. Neri's report and recommendations. Petitioner also complained of left-sided low back pain with radiculopathy to the posterior heel of the left foot. She stated that this pain has been there since the fall. She stated the left lower extremity gives out on her while she is trying to walk. Dr. Burra recommends treating the RSD and aggressive physical therapy before considering surgical intervention for the shoulder. He also recommends a lumbar MRI (PX 4).

Petitioner participated in physical therapy for her right shoulder and elbow at ATI Physical Therapy beginning June 23, 2011 (PX 5). In the Initial Evaluation taken June 23, 2011, Petitioner described her job as baking bread, making sandwiches, cleaning, working the drive thru window, and lifting 20 pounds.

Petitioner testified that she had an incident when her leg went numb and she fell, ending up in the hospital. She denied being in a car accident. She denied chasing her boyfriend and tripping running down a hill. She testified that it goes downhill where she was living. Her leg went numb and she fell hitting the edge of the sidewalk and lost consciousness. She denied being treated for bruising following a domestic issue with her boyfriend. The July 9, 2011 ambulance report states that Petitioner was alert and walking around when they arrived. She had a large hematoma on her face. The ER translator took a story that she was chasing her boyfriend to tell him something and she tripped and fell face first (PX 8, p 17). The trauma consultation report contains a history that she was walking down a slope towards her boyfriend and slipped and fell. Petitioner reported a history of chronic weakness in her left leg and suggests that this may have been the reason she fell as she was walking (PX 8, p 9). The hand-written trauma sheet records a history of running up the stairs and tripped and fell (PX 8, p 14). Petitioner was admitted with a diagnosis of a concussion and post-traumatic seizure. She was released on July 10, 2011 (PX 8, p 10).

Petitioner saw Dr. Burra on July 15, 2011. She gave a history that as she was walking out of her house two weeks ago, her left leg gave out and she fell landing on her right shoulder and landed on her face. She complained of some memory loss symptoms and exacerbation of her right shoulder and elbow. Petitioner had an injection and returned to physical therapy (PX 7). Petitioner had physical therapy for the right shoulder and elbow through January 27, 2012. The notes include a record of a telephone conversation with Petitioner wherein she stated that the bruise on her face was a result of her boyfriend punching her. The record including multiple details of the incident and the abusive relationship (PX 5). At the August 23, 2011 visit with Dr. Burra,

he notes no change in her condition (PX 4). Dr. Neri notes slow progress at his visit on August 30, 2011 (PX 5). The bills admitted (PX 6) show charges for visits with Dr. Burra through January 24, 2012 and with Dr. Neri through April 23, 2012, but no records of this further treatment were offered.

Petitioner had a Functional Capacity Evaluation at ATI on February 1, 2012. The FCE was found to be valid and place Petitioner at the Light Physical Demand Level. The report notes that her regular employment as a cook for Respondent would be considered in the Medium Physical Demand Level. Her current capacity falls below that level (PX 12). Petitioner testified that her doctors gave her restrictions. No doctor has told her she can return to full duty at Respondent. Petitioner testified she returned to work on September 21, 2014 sewing pillows. She sews about 300 pillows per day. This is a light job. She does it primarily with her left arm. She does hold the pillow with her right fingers. She works 40 hours per week and earns $10.30 per hour.

Petitioner testified that she treated with Dr. Bieniek a chiropractor. Dr. Bieniek's records note treatment from August 7, 2014 through November 25, 2014 and on March 15, 2015 (PX 13). Petitioner testified that the treatment let her stretch her hand out a little bit.

Petitioner demonstrated an inability to extend her right arm and contractures of her right little and ring fingers and limited range of her right middle finger. She testified she has constant pain in her right hand. and shoulder. Her right shoulder does not move. She complained of discomfort in her right hip

Conclusions of Law

In support of the Arbitrator's decision with respect to (A) Operating under the Act, the Arbitrator finds as follows:

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. *O'Dette v. Industrial Comm'n, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980)*. In the present case, Petitioner's unrebutted testimony was that she was a cook for Respondent. She testified that she would take care of all the orders and help in the Subway or at the gas station which were located in the same building. The ATI Physical Therapy Initial Evaluation described her job as baking bread, making sandwiches, cleaning, working the drive thru window, and lifting 20 pounds.

The Arbitrator notes that the making of sandwiches would require sharp edged cutting tools as described in Section 3.8 of the Act. Both Dunkin Donuts and Subway serve food to the public for consumption on the premises as described in Section 3.14 of the Act. The making of donuts and brewing coffee place an employee in the hazard of being scalded or burned by hot grease as described in Section 3.14 of the Act. Both businesses and the gas station are businesses in which goods, wares or merchandise are sold to the public, and PX 10 confirms that the payroll for the year preceding the date of injury is greater than $1000 as described in Section 3.17(a) and 3.17(b) of the Act.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that Respondent was operating under the Act on July 18, 2008.

In support of the Arbitrator's decision with respect to (B) Employer/Employee, the Arbitrator finds as follows:

Petitioner's unrebutted testimony was that she was employed by Respondent as a cook. She produced paystubs confirming her employment by Respondent at the time of the accident.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that Petitioner was employed by Respondent Puri Corp d/b/a Dunkin Donuts on July 18, 2008.

In support of the Arbitrator's decision with respect to (C) Accident and (D) Date of Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified that on July 18, 2008, she went to pick up a tray of bread and while putting it on the table, she tripped over a bag of flour, falling on her right elbow and hurting her right index finger and right hip. Central DuPage Hospital emergency room record from July 18, 2008 at 3:18 PM contain histories of Petitioner's symptoms began one hour ago. Patient 'just' fell – no proximate cause," and "Patient slipped at work and fell onto her right shoulder and jammed index finger." The July 22, 2008 x-ray reports note the indication for the test is "fell at work." The August 6, 2008 physical therapy initial evaluation history was that she tripped over a bag of flour on the floor while carrying a tray. While on August 22, 2008, Dr. Bare notes a history of a lifting incident at work, In 2009 both Dr. Burra and Dr. Neri note that history is in error and the accident was falling at work.

The Arbitrator notes that Petitioner's histories, other than that noted by Dr. Bare, are a fall at work consistent with her testimony. The Arbitrator does not find the emergency room notation that she "just fell" inconsistent since it is juxtaposed again the statement that Petitioner is not at risk for chronic falls. The lack of the details does not make the history of a fall inconsistent with her testimony. The Arbitrator notes that the details of the accident were recorded by the initial physical therapy session. The Arbitrator finds the Petitioner's testimony as to the description of the accident credible and consistent with the medical records of initial treatment.

The accident as described by Petitioner occurred in the course of her employment. Carrying a tray while on the employer's premises clearly occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties. The risk of tripping over something while carrying a tray is a risk which is connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified that the injury occurred on July 18, 2008. The Central DuPage emergency room records show that she was treated that afternoon with a history of the fall earlier the same day. The medical records thereafter are consistent in recording of a date of accident on July 18, 2008.

Based upon the record as a whole, the Arbitrator finds that the Petitioner has proven by a preponderance of the evidence that she suffered accidental injuries arising out of and in the course of her employment with Puri Corp. d/b/a Dunkin Donuts on July 18, 2008.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Petitioner's unrebutted testimony was that her accident was witnessed by her boss Dixie Patel and her supervisor Herman. Mr. Patel is listed on the records of the Central DuPage Business Health Work Status reports as the Contact with his phone number listed. The bills were addressed to him.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that she provided Respondent notice of the accident within the time limits stated in the Act.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Commission* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). Through her testimony and medical records, Petitioner has advanced conditions of ill-being in her right upper extremity including the shoulder, elbow and hand, and also in her lower extremities and lumbar spine.

With respect to her lumbar spine and legs, Petitioner testified that she injured her right hip when she fell. The emergency room records do not include complaints in the legs or back. Only x-rays of the right elbow, right hand and right shoulder were taken on July 18. When Petitioner saw Dr. Headley July 22, 2008, Petitioner's pain diagram noted right shoulder and elbow pain and pain on the back of the left hip, not the right. X-rays were taken of the right humerus and left hip/pelvis and demonstrated no fracture. Petitioner had additional follow up visits for her back and left hip with Dr. Headley, but no diagnostic testing was performed. While Dr. Bare recommended referral to Dr. Mayer for the hip and potentially sciatic symptoms on December 5, 2008, Petitioner reported the left hip was doing much better with essentially normal range of motion and an unremarkable straight leg raise. Petitioner had no further treatment until seeing Dr. Burra on June 25, 2009. Dr. Burra notes that Petitioner stated that the left hip pain had completely resolved. There is no further mention of her low back or legs until Petitioner returned to Dr. Burra for follow up on January 31, 2011. Petitioner complained of left-sided low back pain with radiculopathy to the posterior heel of the left foot and that the left lower extremity gives out on her while she is trying to walk. This is the first time these particular symptoms were noted. Her statement that this pain has been there since the fall, made over two years after the accident and 18 months after she told Dr. Burra that the left leg symptoms had resolved, is contrary to those earlier medical records.

The Commission has considered such a gap in care in determining causal connection. See: *Richard Olcikas v. Dominick's Finer Foods, Inc.*, 2009 Ill. Wrk. Comp. LEXIS 1098, affirmed *Olcikas v. IWCC*, 2012 Ill. App. Unpub. LEXIS 26; 2011 IL App (1st) 103274WC-U; 2012 WL 6951575; *Jacob Haltom v. Center for Sleep Medicine*, 2013 Ill. Wrk. Comp. LEXIS 509; 13 IWCC 563, affirmed *Haltom v. IWCC*, 2015 IL App (1st)

133954WC-U; 2015 Ill. App. Unpub. LEXIS 1568; *Jose Ruben Meraz vs. Minute Men Staffing*, 2015 Ill. Wrk. Comp. LEXIS 30; 15 IWCC 30.

The Arbitrator finds that Petitioner never testified to any left leg injury or problems, only the right side. She had gaps in her complaints in her back and legs of over two years, from December 2008 to January 2011, even while undergoing other treatment for her right shoulder and arm. She specifically told Dr. Burra that the symptoms had resolved in June 2009. When she advanced complaints in January 2011, her complaints were of giving way of her leg. This was never noted before that time. No testing or diagnostics were ever performed to determine a cause of her alleged lower extremity symptoms. In fact, no treatment at all was rendered. Arbitrator finds that Petitioner has failed to prove that any low back or leg complaints after December 5, 2008 were causally connected to the accident on July 18, 2008.

After Petitioner's fall on July 9, 2011, Dr. Burra prepared the July 15, 2011 note in which refers to her multiple injuries, all work related. 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. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information. See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Petitioner gave a history that as she was walking out of her house two weeks ago, her left leg gave out and she fell landing on her right shoulder and landed on her face. As noted above, the Arbitrator does not find the left leg and low back condition is causally related. The Arbitrator also notes that Petitioner's statement that her left leg gave out is not consistently reported in the medical records. The ambulance report states that Petitioner was chasing her boyfriend to tell him something and she tripped and fell face first. The trauma consultation report contains a history that she was walking down a slope towards her boyfriend and slipped and fell. Petitioner reported a history of chronic weakness in her left leg only states that this may have been the reason she fell as she was walking. This is more speculation that fact. The Arbitrator also notes the additional records that indicate that the cause of her injuries may have been domestic violence. The Arbitrator finds that Dr. Burra's causation statement is not supported by the evidence, being based on the inaccurate and incomplete information that (1) Petitioner injured her left hip when she testified she hurt her right hip; (2) that Petitioner had ongoing left leg weakness and giving out since the accident when she reported significant improvement in December 2008 and told him that her left leg symptoms were resolved in June 2009 and had never reporting giving out before January 2011; (3) that she had ongoing complaints despite no reporting of left leg issues from December 2008 until January 2011; and (4) that the claim that her left leg gave out causing the her July 9, 2011 fall is not consistently reported in the records and the Arbitrator finds this claim was speculative and unpersuasive.

With respect to her right shoulder and upper extremity, Petitioner advanced immediate complaints to the medical providers from the date of accident forward. Dr. Bare found causal connection to the accident. While

she has had gaps in care, her complaints were consistent as was her diagnosis. The Arbitrator finds the delays were mostly caused by the inability to obtain treatment due to the lack of insurance coverage.

Based upon the Arbitrator's finding above that the lumbar spine and lower extremity conditions were not causally related to the accident, Respondent also raised the argument that the July 9, 2011 incident breaks causation for further ongoing upper extremity care. Based upon the medical evidence and testimony the Arbitrator finds that the Petitioner's current right shoulder and upper extremity complaints remain causally connected to the accident.

A non-employment-related factor which is a contributing cause with the compensable injury in an ensuing injury or disability does not constitute an intervening cause sufficient to break the causal connection between the employment and claimant's condition of ill-being. *International Harvester Co. v. Industrial Comm'n* (1970), 46 Ill. 2d 238, 247, 263 N.E.2d 49, 54. The fact that other incidents, whether work related or not, may have aggravated claimant's condition is irrelevant. *Mendota Township High School v. Industrial Comm'n, 243 Ill. App. 3d 834 at 837, 612 N.E.2d 77 at 79* (4th Dist. 1993). 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 Comp. Comm'n,* (2009) *392 Ill. App. 3d 408 at 411, 911 N.E.2d 1042 at 1046.*

Petitioner was under active care for her right shoulder and arm at the time of the July 9, 2011 episode. The ATI physical therapy records note her condition and the upper extremity treatment. Following this incident, the nature of the treatment did not change. Dr. Burra notes no new conditions, only re-exacerbation the right shoulder adhesive capsulitis, elbow flexion contracture with RSD symptoms and continued clawing of the right hand.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being in the right shoulder, right upper extremity and hand is causally connected to the accidental injuries sustained on July 18, 2008. Petitioner also proved by a preponderance of the evidence that she sustained low back symptoms related to the accident, but said condition reached maximum medical improvement as of December 5, 2008. Petitioner failed to prove by a preponderance of the evidence that any condition of ill-being in her lumbar spine or lower extremities thereafter was causally connected to the accidental injury sustained on July 18, 2008.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Petitioner testified she was making $8.00 per hour. She worked 40 hours per week. Overtime was not included in her paychecks. It was paid separately. She testified she worked Monday through Saturday totaling 40 to 50 hours per week. Her boss would call her when he needed somebody and pick her up. PX 10 lists year to day pay through July 27, 2008 which supports Petitioner's claim that she worked a regular 40-hour week. Petitioner presented PX 11 which she testified was some weeks of her overtime cash payments. There was no evidence that the overtime was mandatory or regular as required to be included in the calculation of average weekly wage under Section 10 of the Act.

Based upon the record as a whole, the Petitioner has proven by a preponderance of the evidence that her Average Weekly Wage is $320.00 per week ($8.00 per hour x 40 hours per week). Based upon the

Arbitrator's finding with respect to Dependents below, Petitioner's rate for TTD would be $213.33 per week and her PPD would be the statutory minimum of $206.67 per week.

In support of the Arbitrator's decision with respect to (H) Age and (I) Marital Status and Dependents, the Arbitrator finds as follows:

Petitioner testified that she was 47 years old on July 18, 2008. The medical records list Petitioner's date of birth as November 21, 1961.

Petitioner's unrebutted testimony was that she was single on the date of accident. Petitioner is claiming 3 dependents. There is no dispute that her two older daughters, Anabel and Belen Vega Heredia are not dependents. Petitioner testified that her youngest daughter Elizabeth Vega Heredia born June 2, 1990, her granddaughter Michelle Ibarra Vega, born August 30, 2013, and her grandson Nestor Duvanne Mejia Vega, born June 23, 1997, are her dependents. Elizabeth is over 18 years old. Petitioner testified that she supported her school but did not provide any information to establish the amount of her support or the nature of the schooling. Michelle and Nestor are not Petitioner's children. Petitioner testified that Nestor lived in Mexico and only testified she sends him money for support. Petitioner testified to the conclusion that Michelle was her dependent but provided no evidence of the nature of the support provided. No evidence that Petitioner had adopted the grandchildren, was under a legal obligation to support the grandchildren, or stood in loco parentis for either grandchild as required by Section 8(b)3 of the Act. was offered.

Based upon the record as a whole, the Arbitrator finds that on July 18, 2008 Petitioner was 47 years old, single and had no dependent children, having failed to prove by a preponderance of the evidence that Elizabeth, Michelle or Nestor would be considered her children pursuant the provisions of Section 8(b)3 of the Act.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission*, 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based upon the Arbitrator's finding with respect to Causal Connection, all reasonable and necessary treatment for the Petitioner's condition of ill-being in the right shoulder and upper extremity, and treatment for her lumbar spine condition only through December 5, 2008 would be causally related and compensable.

Petitioner offered PX 6, being a collection of her alleged outstanding medical bills. The Arbitrator has reviewed the exhibit and the medical records in evidence and finds as follows:

Dr. Bare: The billing of $2985.00 submitted is reasonable, necessary and causally related.
Hinsdale Orthopedics: The billing lists charges through January 24, 2012, but the records offered only document treatment though August 2011. The documented charges for the documented care of $1,149.00 are reasonable, necessary and causally related.

Dr. Neri: The billing lists charges through April 23, 2012, but the records offered only document treatment though August 2011. The documented charges for the documented care of $1,000.00 are reasonable, necessary and causally related.
Walgreens: The prescription charges from Dr. Neri, noted in his records, dated October 11, 2009 of $34.99 are reasonable, necessary and causally related.
ATI Physical Therapy: The charges for physical therapy for Petitioner's right shoulder and upper extremity through January 2012 authorized by Dr. Neri of $53,244.50 are reasonable, necessary and causally related.
IWP: The charges claimed are for prescriptions dated December 2011 through February 2012. As noted above with respect to the bills of Dr. Neri and Hinsdale Orthopedics, no records to document these charges were admitted. The claimed bill of $1,015.43 is denied.
CDH, Winfield Radiology, Winfield lab, DuPage Surgical Consultants, Midwest Neurosurgery & Spine: These bills relate to the July 9, 2011 hospital admission. Based upon the Arbitrator's finding with respect to Causal Connection, the Arbitrator found that the injury suffered July 9, 2011 was not causally connected to the accident and therefore these bills are not causally connected and are denied.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,985.00 to Dr. Bare, $1,149.00 to Hinsdale Orthopedics, $1000.00 to Dr. Neri, $34.99 to Walgreens, and $53,244.50 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Claimant must prove not only that he did not work, but that he was unable to work.

Petitioner initially claimed temporary compensation from the date of the accident forward. After the testimony developed the claim was amended to begin on December 5, 2008, the date Petitioner stopped working for Respondent, Dr. Bare recommended surgical intervention and took Petitioner completely off work. Although Petitioner did not seek further medical care until June 2009 with Dr. Burra, the Arbitrator recognizes that the surgery recommended was not authorized. The Arbitrator further notes that, when Petitioner did seek Dr. Burra, that he diagnosed a significant condition in the right shoulder and arm and initiated a further course of care. The Arbitrator finds that Petitioner was disabled as of December 5, 2008 and entitled to the commencement of temporary total disability at of that date.

Petitioner underwent a Functional Capacity Evaluation on February 1, 2012 which found that she could return to work at the Light Physical Demand Level. Other that a brief period of chiropractic care in 2014, Petitioner offered no further treatment records. It appears that little additional care was offered by Dr. Burra or Dr. Neri after the FCE. Neither Petitioner's condition or her light duty restrictions have changed since the FCE. The Arbitrator finds that Petitioner reached maximum medical improvement as of the date of the FCE on February 1, 2012. Petitioner's entitlement to temporary total disability would have ended as of that date.

Petitioner did not testify to any job search beyond her testimony that she did find a job within her restrictions sewing pillows on September 21, 2014. Section 8(a) provides for both physical rehabilitation and vocational rehabilitation and mandates that the employer pay all maintenance costs and expenses "incidental" to a program of "rehabilitation." However, by its plain terms, Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational-rehabilitation program." *W.B. Olson, Inc., 2012 IL App (1st) 113129WC*; see also *Nascote Industries v. Industrial Comm'n., 353 Ill. App. 3d 1067at 1075*. Thus, if the claimant is not engaging in some type of "rehabilitation" (whether it be physical rehabilitation, formal job training, or a self-directed job search), the employer's obligation to provide maintenance is not triggered. Petitioner failed to establish any such job search or rehabilitation program.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that she was entitled to temporary total disability commencing December 5, 2008 through February 1, 2012, a period of 164 6/7 weeks.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner's date of accident is before September 1, 2011 and therefore the provisions of Section 8.1b of the Act are not applicable to the assessment of partial permanent disability in this matter. In assessing permanent partial disability in this matter, the Arbitrator has only considered the conditions of ill-being found causally connected to the accident.

Petitioner testified that she had problems with her right hip, but the medical records do not support any right-sided lower extremity condition. Petitioner did not testify to any left sided hip complaints as described in the medical records. No treatment for her back of legs since 2011 was offered. The Arbitrator does not find that Petitioner has proven any permanent disability related to any causally connected lumbar spine or lower extremity condition.

Petitioner has a severe restriction of the right arm related to loss of motion in the right shoulder, right elbow and fingers of the right hand. She has undergone periodic treatment for this condition including injections and an extended period of physical therapy. She has been diagnosed with adhesive capsulitis of the right shoulder, a right elbow flexion contracture with RSD symptoms and continued clawing of the right hand. Petitioner demonstrated the limitations of motion and function of her right arm at trial. While Petitioner's treatment has otherwise been limited and she has no treatment other that a short period of chiropractic since 2012, the medical providers, specifically Dr. Burra have documented the course of treatment that they recommended but that Petitioner was unable to pursue this due to lack of coverage.

Petitioner underwent a Functional Capacity Evaluation on February 1, 2012 that found she was at the Light Physical Demand Level. This would not allow her to return to her prior job for Respondent which was estimated at the Medium Physical Demand Level. The Arbitrator notes that, despite her injury, Petitioner performed basically her regular job for almost 5 months after the accident, although she noted in her testimony and medical records that this was due to Respondent's failure to honor her restrictions, she had difficulty performing those duties beyond her restrictions, and that she needed to work slower. As of September 2014, Petitioner has found lighter work sewing pillows that she has been

able to perform for the last 4 years. She demonstrated the limited use of the right arm that she needs to do to complete her present work duties.

Based upon the record as a whole, the Arbitrator finds that Petitioner has suffered a loss of use of the whole person to the extent of 35%.

In support of the Arbitrator's decision with respect to (O) Proof of Insurance and IWBF Responsibility, the Arbitrator finds as follows:

The documentary evidence (PX 1) and Petitioner's testimony establish that Respondent did not have workers' compensation coverage on the date of the accident. Petitioner established proper notice to Respondent, who appeared through counsel for the hearing in this matter. 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC015961
Case Name	CARTER, CHRIS v. SPEEDWAY
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	21IWCC0195
Number of Pages of Decision	26
Decision Issued By	Thomas J. Tyrrell, Commissioner

Petitioner Attorney	David Martay
Respondent Attorney	Mark P Matranga

DATE FILED: 4/23/2021

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	)	[X] Reverse Causal connection	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chris Carter,

Petitioner,

vs. NO: 17 WC 15961

Speedway,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

Petitioner testified he was employed by Respondent on 5/16/17 and that his job title was "[s]ales rep customer service." (T.8). He indicated his job duties included "[s]weeping, mopping, receiving payment for customers, stocking. That's about it." (T.8). He noted that he had worked for Respondent for "[p]robably about three to four months" prior to the accident. (T.8).

When asked to briefly describe how he got hurt on the day in question, Petitioner stated: "[i]t was a spill on the floor. To be exact, the cappuccino machine, and there was [sic] two exact spills, one on the floor and one on the surface of the counter. I walked up to the counter. I was cleaning the countertop first so I wouldn't have to redo the mess. And as I was cleaning the countertop, I guess the oily substance from the cappuccino got – or how do I say I slipped. And

when I slipped, I felt like a buckling sensation in my right leg before I went down. And that's it." (T.8-9). He agreed he fell to the ground and noticed pain immediately in his right knee. (T.9). He noted that he also felt pain in his lower back and head. (T.9). He claimed that his head hit the ground and that he "vaguely" lost consciousness for a couple of seconds. (T.9-10).

He agreed that paramedics were called to the scene and he was transported to Little Company of Mary Hospital. (T.10). He agreed he complained of head and right knee pain at the emergency room and that x-rays were taken of the right knee and a CT scan of the brain. (T.10).

In Little Company of Mary Hospital Emergency Department records dated 5/16/17 it was noted that the patient presented to the ER "… after falling at work. States his right knee locked up causing him to fall backwards hitting the back of his head when he fell. Patient said he does not remember the incident clearly and cannot tell me if he lost consciousness or not. States the fall was witnessed by his supervisor but does not remember of [sic] his supervisors stated that he lost consciousness or not. States ever since she's [sic] had mild headache and sensitivity to light. Denies any double or blurry vision. Denies any nausea or vomiting. Did try standing again while here in the ER however knee started buckling again. States pain is on the lateral aspect of the right knee. Denies any previous injuries. Patient arrived via EMS. No other associated signs symptoms or modifiers." (PX5). A CT scan of the brain was negative for any evidence of intercranial hemorrhage but did note an indeterminate lesion of the occipital bone on the right side most likely representing hemangioma. (PX5). X-rays of the right knee were negative for fractures. (PX5). Petitioner was given a primary diagnosis of right knee pain and a secondary diagnosis of abnormal CT of the brain and told to follow up with his PCP in 2-3 days. (PX5).

Petitioner agreed that he then sought care with Dr. David Schafer on 5/24/17. (T.11). At that visit he noted he complained of head pain, right knee pain and right foot pain. (T.11).

In an office note dated 5/24/17, Dr. Schafer recorded that Petitioner presented with multiple complaints with an acute onset date of 5/15/17 after a work injury while working as a gas station clerk. (PX2). He noted the patient was "… attempting to mop up spilled coffee product by a customer. While cleaning, he slipped and fell. He is unsure of his exact mechanisms of injury as [he] struck the back of his head and lost consciousness." (PX2). He noted he was taken to Little Company of Mary Hospital where x-rays of his knee and a CT scan of his head were obtained. (PX2). Petitioner complained of cervical, lumbar and right knee pain. (PX2).

Petitioner noted that he was prescribed physical therapy and MRIs of the lumbar spine and right knee. (T.11). These MRIs were performed on 6/2/17 at Advantage MRI. (T.12).

An MRI of the lumbar spine performed on 6/2/17 was interpreted as revealing 1) early disc desiccation at L4-5 and L5-S1; 2) grade I retrolisthesis of L5 over S1; 3) Mobic type II endplate degenerative changes at L4-5; 4) 2 mm diffuse disc protrusion at L4-5 with effacement of the thecal sac, disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots, more so on the left side than right; 5) 3 mm diffuse disc protrusion with effacement of the thecal sac at L5-S1, disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L5 exiting nerve roots. (PX2).

An MRI of the right knee performed on 6/2/17 was interpreted as revealing: 1) degeneration and probable tear involving the posterior horn of the medial meniscus; 2) no acute ligament or tendon tear, incomplete visualization of the ACL along the femoral attachment which could be technical in nature or due to partial insufficiency, correlate clinically; 3) small joint effusion and infrapatellar soft tissue edema; 4) no evidence for fracture or significant bone marrow edema. (PX2).

Petitioner agreed that he returned to Dr. Schafer on 6/21/17 and was prescribed physical therapy for both his low back and right knee, which began on 7/13/17. (T.12). He returned to Dr. Schafer on 7/19/17 at which time he was prescribed an epidural steroid injection for his lumbar spine and surgery for his right knee. (T.12-13). He returned to Dr. Schafer on 8/9/17 and 9/6/17 at which time the latter was still prescribing right knee surgery. (T.13). He returned to Dr. Schafer on 10/4/17 at which time he reiterated his recommendation for right knee surgery and referred him to a pain management specialist for an evaluation relative to his lumbar spine. (T.13). Dr. Schafer also continued to recommend PT for the knee and back at that time. (T.13).

In an office note dated 10/18/17, Dr. Intesar Hussain recorded that the patient had been referred to him by Dr. Schafer following a work injury on 5/15/17 [sic]. (PX6). Dr. Hussain's assessment was 1) radiculopathy, lumbar region; 2) spinal stenosis, lumbar region; and 3) other intervertebral disc displacement, lumbar region. (PX6). Dr. Hussain noted that "[t]he patient continues to have significant and persistent lower back pain with radiation to the bilateral buttocks as well as [r]ight knee pain. At this juncture I recommend the patient undergo lumbar epidural steroid injection which will be done via transforaminal approach at the Right and Left L5/S1 under fluoroscopic guidance in the hopes of further relieving his symptoms… He will follow-up with Dr. Schafer to further treat his right knee." (PX6).

Petitioner noted that he saw Dr. Schafer again in follow up from November 2017 through May of 2018 at which time he continued to treat his low back and right knee. (T.13-14). He saw Dr. Schafer again on 10/3/18 and two more times in 2018 – on 11/7/18 and 12/12/18. (T.14). He agreed that at the December visit he related that the pain in his right knee was worsening and that Dr. Schafer prescribed Trazodone and Norco. (T.14-15). He saw Dr. Schafer again on 1/9/19 at which time his prescriptions were refilled. (T.15). He last saw Dr. Schafer on 4/10/19 at which time he related he was having difficulty sleeping due to pain in his right knee. (T.15). He also related that his range of motion in the right knee was getting worse. (T.15). He noted that he is scheduled to see Dr. Schafer again in six weeks. (T.15). He indicated that he is still taking the pain medications every day. (T.16).

Petitioner indicated that he presently works at the Circle K gas station. (T.16). When asked what he does at Circle K, he replied: "[h]onestly, just sit down and collect money because I am not able to move." (T.16). He agreed that he is working as a cashier. (T.16). He denied doing any of the stocking or cleaning that he was doing at Speedway. (T.16). He indicated that he still has pain in his right knee as he sits here today, describing it as a "[t]ingling, stinging, burning, aching pain." (T.16-17). He stated that he was able to walk "[w]ith a limp." (T.17). He noted that the pain in his leg is on the "[i]nside, left side of my knee cap." (T.17). He agreed that Dr. Schafer is still prescribing surgery and that he would undergo said surgery if the Commission were to find in his favor. (T.17-18). He agreed the workers' comp insurance carrier originally

paid some of his bills, and that to his knowledge there are still unpaid bills owed to Dr. Schafer, Little Company of Mary Hospital, Pain Center of Illinois, Premium Health Care Solutions (MRIs), Grand Avenue Surgical Center and Total Rehab. (T.18). He indicated that he has group health insurance but that he has not submitted any of the bills related to his work injury to his insurance. (T.18-19). He denied any pain or complaints or medical care for his right knee prior to the alleged work accident. (T.19). He indicated that he has not been pain-free since the work accident with respect to his right knee. (T.19-20).

On cross examination, Petitioner indicated that his next appointment is six weeks from the last appointment on 4/10/19, or which would take us to around 5/22/19. (T.20-21). He noted that the Circle K he works at is in Orland Hills at 171st and 94th Avenue. (T.22). He stated that he still lives at the same location he did at the time he worked for Speedway – namely, 10038 South Oglesby in Chicago. (T.22). He noted that his girlfriend drives him to work at Circle K and that he works solely as a cashier four days a week. (T.23). He denied stocking the shelves, sweeping or mopping the floors. (T.23).

He indicated that he has not been getting bills in the last few months from Little Company of Mary or any of the doctors or locations where he received medical treatment. (T.23-24). He did recently get a bill from Dr. Schafer and Grand Avenue Surgical Center. (T.24). He claimed it was not for the EPI in his back. (T.24). He sees Dr. Schafer at his office at 17 West Grand in downtown Chicago. (T.25).

Board-certified orthopedic surgeon Dr. David Schafer testified by way of evidence deposition on 11/30/18. (PX1). He noted that he first saw Petitioner on 5/24/17 at which time he recorded the following history: "[t]he patient was working at a gas station. He was a clerk there. There was some spilled coffee on the floor, and he was going to clean it up. He slipped and fell. He can't really remember the exact details of the accident. He fell and hit his head and lost consciousness." (PX1, p.9). At the time of his visit Petitioner complained of neck, low back and right knee pain. (PX1, p.10). With respect to the neck, Dr. Schafer found pain in the paraspinals upon examination, mild to moderate lost motions and a negative Spurling sign. (PX1, p.10). With respect to the lumbar spine he noted tenderness to palpation, moderate to severe loss of motion with reproduced discomfort, mild weakness to the right great toe and ankle dorsiflexion, which he noted was a sign of nerve root problems and secondary weakness, and positive straight-leg raise, which he noted was indicative of lumbar radiculopathy or a pinched nerve in the low back. (PX1, pp.10-11). With respect to the right knee, he noted tenderness to palpation, severe over the medial joint line, which is a sign of a meniscal tear, lost knee flexion, with flexion only to 95 degree, although he could passively get him to 100 degrees, no instability, but with guarding secondary to pain, a positive McMurray and some lost strength from pain. (PX1, pp.11-12). Dr. Schafer ordered an MRI of the knee to look for a meniscal tear and started Petitioner on a course of therapy for his conditions. (PX1, p.12).

Dr. Schafer noted that Petitioner returned on 6/21 at which time he personally reviewed the MRI films. (PX1, p.12). He indicated he agreed with the radiologist in this case and that "[t]here is a small tear of the posterior horn of the meniscus, extending to the inferior articular surface. His ligaments were intact. There was no evidence of degenerative changes." (PX1, p.13). He agreed that these MRI findings were consistent with Petitioner's pain complaints and

physical examination. (PX1, p.13). When asked his treatment plan at that time, Dr. Schafer stated: "[t]he knee tear was small, so I wanted to try an initial course of conservative care before rushing off into surgery. So I felt it was appropriate for him to continue with his physical therapy and return after that to see how he was doing." (PX1, p.14).

Dr. Schafer noted that at the time of this visit he also reviewed the lumbar MRI which revealed "… a disc protrusion at L5-S1, with bilateral neuroforaminal stenosis, hitting the right L5 nerve root." (PX1, p.14). He agreed that these findings were consistent with his physical examination of Petitioner. (PX1, p.14). He recommended continuing therapy with respect to the low back, noting that "[i]f he didn't get better, I was going to refer him to a spine specialist, as I primarily operate on extremities. Well, I shouldn't say primarily. Only." (PX1, p.15).

Dr. Schafer next saw Petitioner on 7/19/17 at which time he noted he only evaluated the knee for some reason. (PX1, p.15). He stated that Petitioner had undergone three therapy sessions by that point, but that his flexion was getting worse. (PX1, pp.15-16). As a result, Dr. Schafer decided it was medically indicated to proceed with right knee arthroscopy and partial meniscectomy. (PX1, pp.16-17).

Dr. Schafer next saw Petitioner on 8/9/17 at which time he noted that the patient's "… knee gave out while he was performing his low back stretches and [he] was having increased pain at that time. It was sharp, still in the medial aspect. And because of the worsening pain, I continued to recommend surgery." (PX1, p.18). With respect to his work status at that time, Dr. Schafer testified "[h]e had been off of work and released, given work notes throughout that he was not – unable to work. At some point when I was no longer treating his back, I put him at sedentary work and said for the physician treating his back to give any further restrictions." (PX1, pp.18-19).

Dr. Schafer next saw Petitioner on 9/6/17 at which time he did not note any significant changes with respect to his recommendation for surgery. (PX1, p.19). He agreed that he was prescribing Norco and Restoril at that time – the former for pain and the latter to help Petitioner sleep at night. (PX1, p.19).

Dr. Schafer next saw Petitioner on 10/4/17 at which time he noted the insurance company had scheduled an IME for Mr. Carter. (PX1, pp.19-20). He agreed that he was still of the opinion at that time that Petitioner required right knee surgery. (PX1, p.20). When asked what he foresaw as an issue or problem in delaying the surgery, Dr. Schafer replied: "… the patient's knee motion was progressively getting worse through his examination… So something was blocked and locked in his knee, which I felt was a meniscus. And the longer he's had with the stiff knee, the weaker it gets and the harder it is to get the motion back and recover. So delay in treatment would, you know, only worsen his overall outcome." (PX1, pp.20-21).

Dr. Schafer stated that he saw Petitioner next on 11/1/17 at which point some improvement in back pain was noted; however, he stated that Petitioner continued to have the same issues with respect to the knee. (PX1, p.21). He indicated he felt Petitioner most likely had a locked bucket handle tear, noting that "[i]t's a known thing that can happen, and the meniscus can kind of where it's torn can flip, like, over on top of itself, and it looks kind of like a bucket

handle when you draw out how the meniscus is torn." (PX1, pp.21-22).

Dr. Schafer next saw Petitioner on 11/29/17 at which time Petitioner reported increased back pain which Dr. Schafer related to "[h]is altered gait probably because he was barely having any motion." (PX1, p.22). He agreed that Petitioner was also still suffering from the same knee pain, and that his recommendation remained to proceed with knee arthroscopy. (PX1, p.22).

Dr. Schafer saw Petitioner again on 12/20/17 and 1/17/18 at which time nothing had changed. (PX1, p.23). He noted that on 2/14/18 Petitioner presented with an IME report by Dr. Bush-Joseph, which he reviewed with the patient. (PX1, pp.23-24). He indicated that he disagreed with Dr. Bush-Joseph's opinion that Petitioner was not a surgical candidate. (PX1, p.24). He noted that the IME basically said there was no mechanism of injury but that "[t]he patient couldn't recall any mechanism of injury. That doesn't mean there was no mechanism of injury. He fell down and hit his head and was knocked unconscious, so he couldn't recall the details. He also stated that the patient was showing hysterical signs. So hysterical means pain out of proportion with kind of the examination. I mean, I had seen this guy for months, and I never saw any signs of symptom magnification. His pain complaints were always consistent. There was nothing that I ever saw that made me guess the validity of his concerns over, like I said, months of care." (PX1, pp.24-25). Dr. Schafer also noted that "[i]t's an orthopedic standard of care to proceed with surgery, at least a diagnostic arthroscopy… Even if [the MRI] said it was no tear, it's still a standard of care after over four months of conservative care to undergo knee arthroscopy for a condition like this." (PX1, pp.25-26).

Dr. Schafer testified that assuming he performs a diagnostic arthroscopy he would expect to see a possible displaced meniscal tear, which he felt was most likely, as well a significant scar buildup or synovitis or possible plica. (PX1, p.26).

Dr. Schafer next saw Petitioner on 4/25/18 at which time Mr. Carter presented with no significant changes with respect to physical findings. (PX1, pp.26-27). His opinion remained that Petitioner was a surgical candidate. (PX1, p.27). The same applied to his visit on 5/23/18. (PX1, p.27). He agreed that he also noted Petitioner would be at MMI if he didn't undergo surgery. (PX1, p.27). He indicated that Petitioner "… was now a year out from his original injury. We had failed to see any improvement of his motion. I felt he would have permanent motion loss and disability without any further surgery. So if he wasn't going to undergo surgery, he would be essentially significantly disabled from the condition." (PX1, pp.27-28).

Dr. Schafer next saw Petitioner on 10/3/18. (PX1, p.28). He agreed it was fair to say that Petitioner wanted to have the surgery done. (PX1, p.28).

Dr. Schafer last saw Petitioner on 11/7/18 at which time he noted no significant changes and that Petitioner was still a surgical candidate in his opinion. (PX1, p.28). That surgery has not been scheduled. (PX1, p.29). He also noted that he has not been provided with a copy of a second report by Dr. Bush-Joseph dated 1/29/17. (PX1, p.29). Dr. Schafer disagreed with Dr. Bush-Joseph if that report claimed the findings on MRI were chronic in nature, noting that the patient was a 28-year old male and "[t]here is no other degenerative changes within the knee. No other signs of cartilage loss damage. It's, you know, not a chronic condition from childbirth. I

mean, people don't have these type[s] of degenerative changes in the meniscus. And it's – and that wasn't my interpretation when I looked at it as well." (PX1, pp.29-30).

Dr. Schaffer testified that it was still his opinion that Petitioner requires right knee surgery as a result of the work injury when he slipped and fell at Speedway. (PX1, p.30). It was also his opinion that the medical care he has provided to date, including prescriptions for physical therapy and medication and the recommendation for surgery, were reasonable and necessary to try to relieve his symptomatic right knee complaints as well as his low back and cervical spine complaints. (PX1, p.30).

On cross examination, Dr. Schafer noted that the patient denied any prior injuries or problems to his right knee. (PX1, p.31). He agreed that he felt Petitioner's knee condition was not chronic given his age and history, noting that it was "… also based off the other radiographic findings of no other signs of degenerative changes through the knee." (PX1, p.31). He agreed that the radiologist's impression was degeneration and probable tear of the posterior horn. (PX1, pp.31-32). However, he indicated that "[i]n a 28-year old with no other prior history, with no other signs of degenerative changes throughout the knee, I think more likely it's acute and not chronic. There is [sic] no other signs that this was a chronic condition." (PX1, p.32). He also felt that the tear extended all the way through the inferior articular part and that "… right now it's to the superior part because once it gets all the way through, then that meniscus is likely displaced." (PX1, p.33). He agreed that his interpretation is that Petitioner's condition has worsened since the MRI and that the meniscus injury has developed into something more substantial. (PX1, p.33). He indicated that the patient was stable from about 5/24 to 8/9/17 and that he was in therapy and the knee became locked, and it has never become unlocked. (PX1, p.35). He noted that the last time he saw Petitioner his flexion was 45 degrees. (PX1, p.36). He stated at as a result Petitioner "… walks very stiff-legged with it slightly flexed." (PX1, p.38).

Dr. Schafer agreed that he disagreed with the IME report's claim that Petitioner was exaggerating his symptoms or presenting hysterically. (PX1, p.40). He noted that he had Petitioner off work while he was treating all of his conditions going back to May of 2017. (PX1, pp.40-41). His guess was that Petitioner underwent physical therapy for his back for maybe four months. (PX1, p.41). He agreed that at that time he referred Petitioner to a spine specialist, although he did not know if Mr. Carter ever went. (PX1, p.41). He indicated that he documented lumbar exams up until September [presumably of 2017]. (PX1, p.42). However, he then said he may be confused as to the date. (PX1, pp.42-43). He indicated he never said Petitioner was no longer in need of low back treatment, only that he was released from his care to see a specialist. (PX1, p.43). He noted at that point he was just treating the knee. (PX1, pp.43-44). He also indicated that "I am not here to give an opinion on his current condition on his lumbar spine." (PX1, p.44). However, it was his impression that Petitioner's back condition had improved, even though he is still having it. (PX1, pp.45-46). He noted that he currently has Petitioner off of work for the knee. (PX1, p.46). He said he was going off the patient's history that he was off work for the back, noting that "I don't have anything in my chart of his back since he was referred out." (PX1, p.47).

Dr. Charles Bush-Joseph testified by way of evidence deposition on 12/11/18. (RX1). He agreed that he is a specialist in orthopedic surgery and is currently a Professor of Orthopedic

Surgery at Rush University Medical Center as well as team physician for the Chicago White Sox. (RX1, pp.5-6). He noted that approximately 60% of the patients he sees and the surgeries he performs deal with knee injuries. (RX1, p.6). He agreed he examined Petitioner on 10/6/17 and that as a result he generated two reports – one dated 10/6/17 and an addendum dated 12/29/17. (RX1, pp.6-7). He recorded that Petitioner was a 28-year old right hand dominant male with no history of injury, treatment or trauma to the right knee prior to a slip and fall on 5/15/17. (RX1, p.7). He noted that Petitioner "… was a three-month employee of a Speedway Service Center … [who] was cleaning one of the café machines when he slipped, falling backwards injuring his low back, his head. And he claimed that he injured his right knee. But I note in my records I couldn't reconcile the mechanism of – you know, specifically how he fell; whether he twisted the knee or a direct blow to the knee. The patient couldn't relate that to me… I remember him saying, yeah, I slipped. I was on wet surface, or I can't remember what, and he fell backwards… [l]anding on his back and striking his head." (RX1, pp.7-8).

Dr. Bush-Joseph also noted that Petitioner "… walked with an inconsistent antalgic gait, which means that it wasn't a reproducible pattern… I hate to say it, in the report I used a hysterical gait. I mean that he had gyration movements that were not typical of a specific injury pattern." (RX1, p.9). He indicated that "hysterical gait" was "a Bush-Joseph term… That was Dr. Bush-Joseph's opinion of my interpretation of the physical exam findings at the time." (RX1, pp.9-10). He noted Petitioner was unwilling to flex his knee beyond 45 degrees in a sitting position, but that "… when I asked him to sit in the chair, he easily sat down with his knee flexed to 90 degrees", which he felt was inconsistent. (RX1, p.10). He also felt the exam of the knee itself was benign, with no effusion or fluid on the knee, stable ligament testing and no specific joint line tenderness, noting that "[h]e was just tender everywhere." (RX1, pp.10-11). He also felt Petitioner was moving his knee in a much more comfortable fashion when he was examining his back. (RX1, p.11). In addition, he noted that Petitioner wouldn't lay down on the exam table because he said he was in too much pain and spasm. (RX1, p.11).

Dr. Bush-Joseph indicated that the MRI report dated 6/2/17 noted a possible degeneration and probable tear of the medial meniscus and a small questionable effusion. (RX1, p.12). He later reviewed the films and noted that they "… did show intermeniscal signal changes in the posterior horn of the medial meniscus which are chronic in nature. There is no evidence of a joint effusion." (RX1, p.13). He stated that he did not think there was an effusion or findings consistent with an acute injury. (RX1, p.13). He noted that "… the meniscus was clearly not normal. But the age of the condition is undetermined based on the findings on the MRI scan. There was nothing suggestive of an acute tear at that time based on presence of large amounts of fluid in the region or other soft tissue damage." (RX1, p.13). He indicated that he would have expected more acute findings, given that the MRI was done about two weeks after the accident. (RX1, pp.13-14).

Dr. Bush-Joseph's diagnosis was "… right knee pain of unclear etiology… His mechanism of injury of falling backward striking his lumbar spine and striking his head such that he had an emergency CT scan of the brain is not typical of a patient suffering a rotational twisting injury to the knee that – and subsequently producing an acute traumatic event." (RX1, pp.14-15). He also noted that "I saw no specific findings of objective injury to his knee that warranted a work restriction." (RX1, p.15).

With respect to his review of the MRI films themselves, he noted that "… the MRI findings are consistent with the radiology report. The patient's physical findings were hysterical in nature… Certainly, the MRI findings are more likely than not chronic. I do not see specific findings of the lumbar spine." (RX1, p.15).

When asked his opinion regarding Dr. Schafer's belief that Petitioner's knee condition has perhaps evolved to the point where he is in need for surgery, Dr. Bush-Joseph indicated that "I honestly can't comment on the condition of the patient after October 6, 2017." (RX1, p.16). He agreed that a bucket handle tear could produce a locking event, and that it was possible that such an event occasioned by a fall could be attributable to a bucket handle tear. (RX1, p.16).

On cross examination, Dr. Bush-Joseph indicated he does anywhere from one to three IMEs a week and that 90 percent are for Respondents. (RX1, p.17). He agreed the MRI he looked at shows a small tear of the posterior horn of the medial meniscus and that the ACL is intact. (RX1, p.18). He noted that the tear appeared to be chronic in nature based on the objective findings at the time. (RX1, p.18). He noted that Petitioner clearly denied prior treatment or injury to the shoulder, back, knee, hip or head. (RX1, p.18). He agreed that based on the records provided by the insurance company, there was no prior treatment for the knee. (RX1, p.18). He agreed that Petitioner claimed the injury occurred when he was mopping the gas station floor and slipped and fell backwards. (RX1, p.19). However, when asked about the emergency room report noting that his right knee locked up causing him to fall backwards, Dr. Bush-Joseph stated that Petitioner "… was not as specific to me about the condition… [about] where [the right knee] was positioned or such. As I recall, he told me I slipped on the wet floor and went backwards. So that element did not come out during the course of the examination." (RX1, p.19). When asked to assume that the emergency room history was correct, and the right knee locked up when he fell back, Dr. Bush-Joseph agreed it was possible that something like that could cause a meniscal tear. (RX1, p.19). He also agreed that it was possible that it could aggravate a preexisting chronic meniscal tear. (RX1, pp.19-20).

Dr. Bush-Joseph noted that he felt it significant that Dr. Schafer appeared unsure of the etiology "[b]ecause I would generally say that 99 percent of surgeons say they see a meniscus tear after a traumatic injury, they're going to want to operate right away. So I felt that was significant by Dr. Schafer's perspective that he, quote, did not see the need nor desire to operate right away on this condition." (RX1, p.20). He agreed that Dr. Schafer initially put off surgery for a course of conservative care. (RX1, p.21). He also agreed that pain along the medial joint line of the knee was consistent with somebody that has a meniscal tear. (RX1, p.21). He conceded that some meniscal tears, if left untreated, could enlarge with further time or injury leading to a greater necessity of care, and that it was possible that an untreated meniscal tear can create mobility issues. (RX1, p.21). He agreed that a bucket handle tear cannot be fixed without surgery. (RX1, pp.21-22). He did not have a specific memory of, and thus could not comment on, whether the records referenced that Petitioner was exaggerating or amplifying his symptomatic pain complaints with respect to his knee. (RX1, p.22).

When asked whether he would expect Dr. Schafer to find a bucket handle tear at surgery, Dr. Bush-Joseph noted "… I'm not going to question Dr. Schafer's judgment to say that based on the evolution of the patient's symptoms with time, that he believes surgery is indicated… [I]s

there pathology of the medial meniscus on the MRI? Yes." (RX1, pp.22-23). However, he stated that given that the MRI occurred within two weeks of the injury with little or no findings, and the findings were deemed to be chronic or degenerative by even the radiologist, that "… leads me to believe that more likely than not there may have been a preexisting condition there." (RX1, p.23). He noted that if Dr. Schafer finds a bucket handle tear it "… may have been there prior to the work-related event, or it may have been aggravated or worsened after the work-related event. All I can say is at the time of my examination, you know, that the patient had nonspecific findings. He had no objective swelling. He had – unfortunately, I mentioned before, hysterical examination findings that led me to believe that I could not corroborate his condition from a specific work-related event, especially with his description of the mechanism of injury. A fall backwards, yes, can produce lumbar pain and head contusion. But to tear a bucket handle meniscus, usually it's a major pivoting event. Patients don't land on their back. They don't fall backwards and strike their head and neck. They fall forwards. They generally twist on their knee, and they go down in the front, and they end up with contusion. They end up with large amounts of swelling, which I – you know, which at the time of my exam, I just didn't note." (RX1, pp.23-24).

He agreed that according to the ER history his right knee locked up when he fell back, noting that the ER report references an injury to the right knee. (RX1, p.24). He also once again agreed that it was possible that the locking of the right knee could cause a tear or at least aggravate an underlying tear. (RX1, p.24).

On re-direct, Dr. Bush-Joseph agreed that it was possible the knee locking could have caused the fall. (RX1, p.25).

In an IME report dated 12/12/17, and following his record review, Dr. Frank Phillips stated that following his review of the records he was of the opinion that "… Mr. Carter likely sustained a lumbar sprain/strain. He has axial low back pain without any radicular neurologic symptoms. This is further complicated by the knee injury for which he apparently requires surgery. With regard to his spine, I would recommend he complete another month of therapy. Once he completes an 8-week course of therapy, I believe he likely will have reached MMI. He does not have radicular complaints. I do not believe he requires any injection therapies. Once he completes the conservative course, I would anticipate him resuming regular duty. In the interim from a lumbar point of view, Mr. Carter could work with a 20-pound lifting restriction. Obviously, I would defer to his knee specialist with regard to knee-related restrictions." (RX2). He concluded that the "[p]rognosis for return to full unrestricted work as it relates to the lumbar spine is excellent." (RX2).

Conclusions of Law

It is well-settled that the Commission may infer causation from a sequence of lack of symptoms prior to an industrial accident, with symptom manifestation immediately following the accident. *Steak 'N Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC (3rd Dist. filed 11/17/16); citing *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 207-208 (2003); *United Coal Mining Co. v. Industrial Commission*, 318 Ill.App.3d 170, 175 (2000).

It has long been recognized that, 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. *Sisbro, Inc.*, 207 Ill.2d 193, 204-206, 797 N.E.2d 665, 278 Ill.Dec. 70 (2003); citing *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); *Azzarelli Construction Co. v. Industrial Comm'n*, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); *Fitrro v. Industrial Comm'n*, 377 Ill. 532, 537, 37 N.E.2d 161 (1941).

Based on the above, and the record taken as a whole, the Commission reverses the Arbitrator and finds that Petitioner's current condition of ill-being with respect to his right knee is causally related to the accident on 5/16/17. In support of this finding the Commission relies on the opinion of board-certified orthopedic surgeon Dr. Schafer who indicated that when he first examined Petitioner on 5/24/17 he complained of neck, low back and right knee pain, and that the right knee MRI performed on 6/2/17 revealed a small tear of the posterior horn of the meniscus extending to the articular surface, which he noted was consistent with Mr. Carter's pain complaints and physical examination. Unlike the Arbitrator, the Commission is not persuaded by the opinion of Respondent's §12 examining physician, Dr. Bush-Joseph, to the effect that Petitioner's right knee symptoms were chronic in nature and not caused by the accident. Dr. Schaffer disagreed with this assessment, and disputed Dr. Bush-Joseph's claim that Petitioner exhibited signs of symptom magnification, or what he called "hysterical gait", noting that in a 28-year old individual with no prior history of knee problems or other signs of degenerative changes throughout the knee, the injury was more likely acute. The Commission finds Dr. Schaffer's opinion along these lines to be more reasonable under the circumstances, particularly given Petitioner's ongoing complaints and current need for surgery. Furthermore, even Dr. Bush-Joseph agreed that the history noted in the emergency room record -- namely, that the right knee locked up when Petitioner fell backwards – could possibly cause a meniscal tear, and that it was possible such a mechanism of injury could aggravate a preexisting chronic meniscal tear. (RX1, pp.19-20). He also agreed that it was possible that the locking of the right knee could cause a tear or at least aggravate an underlying tear. (RX1, p.24). Thus, the Commission finds that at the very least Petitioner suffered an aggravation of a pre-existing condition relative to his right knee, and that his current condition of ill-being with respect to said injury is causally related to the accident on 5/16/17.

With respect to the lumbar spine, the record shows that at the time of his initial examination on 5/24/17, Dr. Schafer noted tenderness to palpation, moderate to severe loss of motion with reproduced discomfort, mild weakness to the right great toe and ankle dorsiflexion, which he noted was a sign of nerve root problems and secondary weakness, and positive straight-leg raise, which he noted was indicative of lumbar radiculopathy or a pinched nerve in the low back. (PX1, pp.10-11). An MRI of the lumbar spine performed on 6/2/17 was interpreted as revealing 1) early disc desiccation at L4-5 and L5-S1; 2) grade I retrolisthesis of L5 over S1; 3) Mobic type II endplate degenerative changes at L4-5; 4) 2 mm diffuse disc protrusion at L4-5 with effacement of the thecal sac, disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots, more so on the

left side than right; 5) 3 mm diffuse disc protrusion with effacement of the thecal sac at L5-S1, disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L5 exiting nerve roots. (PX2).

On 10/4/17, Dr. Schafer referred Petitioner to a pain management specialist for an evaluation concerning his lumbar spine. Petitioner thereupon visited Dr. Hussain on 10/18/17 at which time he was given a diagnosis of 1) radiculopathy, lumbar region; 2) spinal stenosis, lumbar region; and 3) other intervertebral disc displacement, lumbar region. Dr. Hussain noted that Petitioner continues to have significant and persistent lower back pain with radiation to the bilateral buttocks and recommended a lumbar epidural steroid injection. (PX6).

In a report dated 12/12/17, §12 record reviewer Dr. Phillips noted a diagnosis of lumbar sprain/strain and recommended that Petitioner complete an 8-week course of therapy, at which point he will have reached MMI. Dr. Phillips also noted that Petitioner did not have radicular complaints and that he did not believe he required any injection therapy. Dr. Phillip anticipated that Petitioner would be able to resume regular duty with respect to his lumbar spine once he completed conservative care, and in the interim could work with a 20-pound lifting restriction. However, he noted that he would defer to Petitioner's knee specialist with regard to any knee-related restrictions.

For his part, Dr. Schafer did not offer an opinion as to Petitioner's low back condition, although he did note that he believed Mr. Carter's condition had improved in this regard, even though he still had symptoms. The Commission notes that there is no evidence that Petitioner has sought treatment for his lumbar spine since his visit to Dr. Hussain. Petitioner likewise did not testify to any ongoing lower back complaints at the time of trial. As a result, the Commission finds Petitioner reached maximum medical improvement with respect to his lumbar spine as of 2/5/18, or approximately eight (8) weeks subsequent to the date of Dr. Phillips' report, and that a causal relationship existed between the accident and Petitioner's lumbar spine condition through that date.

Furthermore, in light of the above holding as to causation, the Commission finds that Petitioner is entitled to reasonable and necessary medical expenses through the date of arbitration (1/15/20) for the treatment of his right knee injury and through 2/5/18 with respect to the lumbar spine injury, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. The Commission also finds that Respondent is entitled to a credit for any amounts paid on account of the injury under §8(j) of the Act.

Finally, in light of the above holding as to causation, the Commission finds that Petitioner is entitled to prospective care and treatment recommended by Dr. Schafer, including a right knee arthroscopy and partial meniscectomy, pursuant to §8(a) and §8.2 of the Act. Along these lines, Dr. Schafer testified that "[i]t's an orthopedic standard of care to proceed with surgery, at least a diagnostic arthroscopy… Even if [the MRI] said it was no tear, it's still a standard of care after over four months of conservative care to undergo knee arthroscopy for a condition like this." (PX1, pp.25-26). Indeed, even Dr. Bush-Joseph, testified that "… I'm not going to question Dr. Schafer's judgment to say that based on the evolution of the patient's symptoms with time, that he believes surgery is indicated… [I]s there pathology of the medial meniscus on the MRI? Yes."

(RX1, pp.22-23). Thus, the Commission orders Respondent to authorize and pay for the surgery proposed by Dr. Schafer.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/14/20 is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses related to the right knee through 1/15/20 and for the lumbar spine through 2/5/18, pursuant to §8(a) and the fee schedule provision of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment recommendations of Dr. Schafer, including a right knee arthroscopy, 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 pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. 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: **4/21/2021**

o:2/23/21
TJT/pmo
51

/s/ *Thomas J. Tyrrell*

/s/ *Maria E. Portela*

/s/ *Kathryn A. Doerries*

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

CARTER, CHRIS
Employee/Petitioner

Case# **17WC015961**

SPEEDWAY
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICE
DAVID W MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
MARK P MATRANGA
20 N CLARK ST SUITE 1000
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)

Chris Carter
Employee/Petitioner

v.

Speedway
Employer/Respondent

Case # **17 WC 15961**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **April 29, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/16/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,246.84**; the average weekly wage was $**331.67**.

On the date of accident, Petitioner was **28** 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 of $**0** under §8(j) of the Act.

ORDER

The Arbitrator finds Petitioner proved that he sustained soft tissue sprains/strains to his lumbar spine and into his right knee that were causally related to his work accident. The Arbitrator finds that Petitioner achieved MMI with regard to his lumbar spine, as noted by Dr. Frank Phillips. The Arbitrator finds that Petitioner failed to prove that he sustained an acute tear of his right medial meniscus.

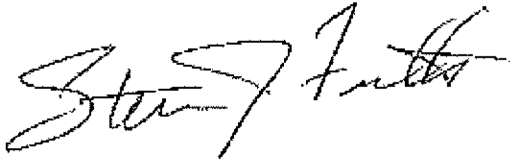
The Arbitrator denies Petitioner's claim for prospective medical care.

The Arbitrator awards all treatment with regard to the lumbar spine at Total Rehab for physical therapy through October 25, 2017. With regard to the right knee, the bills of Dr. Schafer are awarded through October 6, 2017. If not already paid, the emergency room bills of Little Company of Mary are awarded as are the bills from the MRI facility where the lumbar and right knee MRI studies were performed on June 2, 2017. All bills to be adjusted in accord with the Medical Fee Schedule provided in §8.2 of the Act. The bills of Dr. Hussain/The Pain Center of Illinois and Grand Avenue Surgical Center are denied.

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

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

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



Signature of Arbitrator

April 6, 2020
Date

APR 1 4 2020

CHRIS CARTER v. SPEEDWAY, LLC
17 WC 15961

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?

STATEMENT OF FACTS

Petitioner Chris Carter was employed by Respondent Speedway as a sales representative and customer service representative. He had been working in this position for approximately 3 to 4 months prior May 16, 2017. In these positions, he would stock materials on the shelves of the store and service customers. He would also perform routine maintenance functions. On the date in question, he was cleaning the counter and floor where cappuccino had spilled. While performing this task, he slipped on the liquid, and fell, striking his head and back. He described a buckling sensation in the right knee as he fell and experiencing low back pain. He may have lost consciousness for approximately 2 seconds.

Petitioner was transported to Little Company of Mary where he reported head and right knee pain. Petitioner presented with a history of his right knee locking up which caused him to fall backwards. He could not remember the incident clearly and could not recall if he lost consciousness. He was complaining of headaches and sensitivity to light. The right knee examination revealed decreased range of motion secondary to pain. An X-ray of the knee was negative. A CT scan of the brain was negative except for a sclerotic lesion of unknown origin, but most likely considered a hemangioma. He was discharged and followed up with Dr. David Schafer on May 24, 2017.

Petitioner presented to Dr. Schafer May 24 with complaints of neck, low back and right knee pain from a fall at work while cleaning some spilled coffee which was on the floor. He could not recall the exact mechanism of injury but reported striking his head and losing consciousness. He reported cervical pain radiating to the right upper trapezius and scapular region. He also noted midline pain in the lower lumbar region which had radiated into the bilateral lower extremity but that had improved. He also complained of right knee pain on both medial and lateral aspects.

Dr. Schafer diagnosed a cervical strain, lumbar pain, right knee pain, and recommended therapy. Dr. Schafer ordered MRIs of the lumbar spine and right knee.

The lumbar MRI revealed generalized disc protrusions. The right knee MRI revealed a probable tear of the posterior horn of the medial meniscus Petitioner began physical therapy at Total Rehab on July 13, 2017.

When Petitioner saw Dr. Schafer on July 19, 2017, he reported no improvement with any of his complaints. Dr. Schafer then changed his recommendation and recommended surgery: a partial meniscectomy and debridement. Petitioner's low back condition had not improved with conservative care and recommended an epidural injection and referral to a pain management specialist. He advised continued physical therapy until evaluated by a specialist.

When Petitioner saw Dr. Schafer August 9 and again on September 6, 2017, the doctor also discussed surgery. When Petitioner followed up on October 4, 2017, Dr. Schafer again recommended surgery, additional therapy and also referred Petitioner to pain management.

Petitioner has followed up with Dr. Schafer on multiple occasions since October 2017. He saw the doctor in November and December 2017 as well as in January and February 2018. He followed up in April and May 2018 when he also complained of his low back. (PX 2). More recently, he saw the doctor on October 3, 2018, on November 7, 2018, and December 12, 2018. The doctor refilled prescriptions for Tramadol and Norco on January 9, 2019. Petitioner also saw Dr. Schafer April 10, 2019. Dr. Schafer finds decreased the range of motion of Petitioner's right knee to have decreased. Petitioner is currently taking pain medication on a daily basis and expressed the desire to undertake the proposed surgery.

Dr. Schafer testified to the above treatment recommendations at the time of his evidence deposition. He reiterated his treatment recommendations up to and including his most recent report of encounter with Petitioner on April 10, 2019. He testified that Petitioner's condition had remained unchanged. There tenderness to palpation over the medial joint line on the right knee and diffuse pain to palpation throughout the hip and the medial femoral condylar region. He also noted limited motion in the hip. Petitioner was walking with an antalgic gait with the knee flexed at five degrees. He testified that Petitioner looked worse than at the last office visit and had lost further motion. Dr. Schafer noted that "at the time I saw him, 28-year-old male. There is no other degenerative changes within the knee. No other signs of cartilage loss damage. It's, you know, not a chronic condition from childbirth. I mean, people don't have these types of degenerative changes in the meniscus ." He recommended surgery as well as an aggressive home exercise program to help with lost motion

Petitioner participated in 21 therapy sessions at Total Rehab from July 13 through October 25, 2017. He was discharged November 17, 2017 after having not appeared for 5 consecutive sessions.

Petitioner was examined pursuant to §12 of the Act by Dr. Frank Phillips at Midwest Orthopaedics at RUSH on September 12, 2017 (RX #2). Dr. Phillips exam was limited to Petitioner's back complaints. Dr. Phillips noted tenderness to "barely palpating the lumbar spine." Lumbar range of motion was only about 15° flexion and extension subjectively limited by complaints of low back pain. Strength in the left lower extremity was normal. On the right, there was giveaway weakness which Petitioner attributed to right knee pain. Straight-leg raise was negative. The doctor noted the MRI revealed mild degenerative changes with no evidence of acute structural injury.

Dr. Phillips opined that Petitioner sustained a lumbar sprain/strain. There were no particular neurological symptoms displayed. He recommended another month of therapy after which he opined that Petitioner would reach MMI. There were no radicular complaints. Therefore, Petitioner did not require any injection therapies. Dr. Phillips would impose a 20-pound lifting restriction in the interim from a lumbar point of view. He anticipated that these restrictions would last for the duration of the additional period of therapy, with a full and unrestricted return to work thereafter with regard to the lumbar spine.

Dr. Schafer referred Petitioner to Dr. Hussain at the Pain Center of Illinois where he evaluated Petitioner on October 18, 2017. Petitioner presented at that time with low back and right knee pain. He reported having had 20 therapy sessions with no significant improvement of symptoms. He was taking Norco for pain. Dr. Hussain reviewed the June 2, 2017 lumbar MRI, which demonstrated diffuse disc protrusions at L4-5 and L5-1 as well as disc dissection at both levels and Grade I retrolisthesis at L5-S1. Dr. Hussain diagnosed radiculopathy and spinal stenosis of the lumbar region. Dr. Hussain recommended a lumbar epidural steroid injection, which was performed on February 28, 2018 at Grand Avenue Surgical Center.

Orthopedic surgeon Dr. Charles Bush-Joseph of Midwest Orthopaedics at RUSH examined Petitioner pursuant to §12 of the Act on October 6, 2017. He found Petitioner's examination hysterical in nature, with no objective physical findings or on clinical exam. He reviewed Dr. Schafer's reports and indicated that even Dr. Shafer felt there was no indication for surgical management. There was no effusion, no specific joint line tenderness, and no physical findings, nothing that would explain Petitioner's resistance on range of motion testing that was present only on active exam. Dr. Bush-Joseph opined that Petitioner was able to return to work on a full

duty basis, unrestricted.

Dr. Bush-Joseph reviewed the MRI films later and noted intermeniscal signal changes in the posterior horn of the medial meniscus which appeared chronic in nature. There was no clear evidence of joint effusion. He considered these findings consistent with his earlier examination. He also reviewed the lumbar MRI and concluded that there to be mild disc degeneration at L5-S1 with no evidence of herniation, extrusion, or neuroforaminal stenosis.

After reviewing the MRI films, Dr. Bush-Joseph felt that the scan was consistent with the radiology report and with his physical exam. The doctor reiterated his opinion that the exam was hysterical in nature: inability or unwillingness to move the knee beyond 90° and a distracted manner that did not correlate with any objective physical findings or radiographic imaging studies. The MRI findings were chronic. Dr. Bush-Joseph did not see specific findings in the lumbar spine or any further treatment. He did not see the need for specific treatment.

At his evidence deposition Dr. Bush-Joseph testified consistently with his reports. On cross-examination he acknowledged that the June 2, 2017 MRI did show a small tear of the posterior horn of the medial meniscus. His opinion was that it appeared to be chronic in nature. Also, Dr. Bush-Joseph testified that the injury Petitioner described to the physicians at Little Company of Mary Hospital could have caused a meniscal tear or could have aggravated a preexisting chronic meniscal tear.

On October 4, 2017 Petitioner saw Dr. Schafer, who again recommended right knee surgery. He also recommended pain management for his lumbar spine, continue therapy, and remain off work.

Petitioner saw Dr. Schafer for follow-up visits on November 1, November 29, and December 20, 2017. Dr. Schafer continued to opine that Petitioner required right knee surgery. On January 17, 2018 Dr. Schafer noted that the delay in right knee surgery was severely detrimental.

On February 14, 2018 Petitioner presented a copy of Dr. Bush-Joseph's IME report to Dr. Schafer. Dr. Schafer noted several disagreements with Dr. Bush-Joseph's opinions. Specifically, he noted that he never saw any signs of symptom magnification and noted that "his pain complaints were always consistent." Dr. Schafer also noted that after months of failing conservative care, "It's an orthopedic standard of care to proceed with surgery, at least a diagnostic arthroscopy."

Petitioner testified that he continues to experience a lot of right knee pain every single day. He walks with a limp. In order to make a living, he is working as a cashier at Circle K, but he only works the register from a sitting position. He does not do any other duties like cleaning the store. Petitioner testified that he would still like to undergo the surgery recommended by Dr. Schafer in order to help relieve his right knee pain.

Petitioner introduced into evidence the following bills: Adult & Pediatric Orthopedics - $990.00; Little Company of Mary Hospital - $4,528.00; The Pain Center of Illinois - $543.00; Premium Healthcare Solutions - $4,822.00; Grand Avenue Surgical Center - $15,778.00

CONCLUSION OF LAW

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

Based on the description of the accident, mechanism of injury, and the opinions of various physicians, the Arbitrator finds a causal connection between the accident and the condition of Petitioner's right knee. The Arbitrator finds Petitioner sustained a sprain/strain of the right knee. The Arbitrator also finds that there a causal connection between the incident in question and Petitioner's low back condition, a lumbar sprain/strain.

The Arbitrator bases these conclusions on the opinions of Drs. Phillips and Bush-Joseph. Dr. Phillips opined that Petitioner could benefit from an additional month of physical therapy but that he otherwise displayed no radicular symptoms; the lumbar MRI revealed mild degenerative changes. There were no neurological deficiencies noted on exam. Dr. Bush-Joseph considered Petitioner's exam abnormal in that it was "hysterical." However, he did indicate that Petitioner sustained a knee strain, albeit there was no pathology of significance noted on the MRI.

Petitioner's treating physician, Dr. Schafer, diagnosed an acute tear of Petitioner's right medial meniscus. Dr. Bush-Joseph diagnosed a chronic tear if the meniscus. The Arbitrator finds Dr. Bush-Josephs opinion more persuasive by virtue of his professional qualifications. He, like Dr. Schafer, is board-certified in orthopedic surgery. However, Dr. Bush-Joseph teaches orthopedic surgery to medical student and resident physicians. He has published medical articles in peer-reviewed professional journals. He has served on the editorial board of professional journals, such as *American Journal of Sports Medicine*. He served as president of the American Orthopaedic Society for Sports Medicine. Dr. Bush-Joseph's qualifications lends the gravitas to his opinions that make them so persuasive. His experience and qualifications persuaded the Arbitrator that Petitioner sustained only a sprain/strain

of the right knee overlying a chronic tear of the medial meniscus.

In that same vein, the Arbitrator finds the opinions of Dr. Phillips, due to his superior qualifications, equally as persuasive as those of Dr. Bush-Joseph. Dr. Phillips diagnosed a lumbar sprain strain at his IME on September 12, 2017. He opined that petitioner could benefit from an additional short-term physical therapy after which he should attain MMI. Dr. Phillips also opined that following the additional physical therapy Petitioner could return to full duty work. The Arbitrator finds these opinions persuasive due to the doctor's qualifications as professor orthopedic surgery and director of the division is spine surgery at Rush University Medical Center, as well as author of numerous research-based peer-reviewed articles. Like Dr. Bush-Joseph, Dr. Phillips teaches orthopedic surgery to medical students and resident physicians. The weight of his qualifications and experience as well as his clinical findings of symptom magnification persuaded the arbitrator that his opinions are reasonable.

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 the treatment Petitioner received in this claim from the date of the accident through the examination with Dr. Phillips with regard to the lumbar spine and with Dr. Bush-Joseph with regard to the right knee was reasonable and necessary medical treatment. Therefore, all treatment with regard to the lumbar spine at Total Rehab for physical therapy through October 25, 2017 is hereby awarded. With regard to the right knee, the bills of Dr. Schafer are awarded through October 6, 2017. If not already paid, the emergency room bills of Little Company of Mary are awarded as are the bills from the MRI facility where the lumbar and right knee MRI studies were performed on June 2, 2017.

The bills of Dr. Hussain/The Pain Center of Illinois and Grand Avenue Surgical Center are denied based on Dr. Phillips' IME report. Dr. Phillips was of the opinion that Petitioner was not in need of any additional treatment with regard to the low back condition. There is no support for the claim that Petitioner needs treatment for his low back.

Any Dr. Schafer, Total Rehab, or Little Company of Mary Hospital bills already paid shall be credited to Respondent. All bills unpaid and awarded are subject to the adjustment in accord with the Medical Fee Schedule provided by §8.2 of the Act.

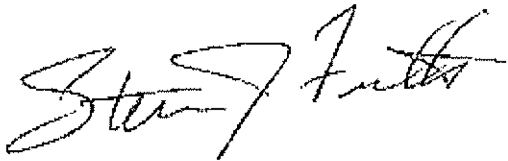
K: Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner sustained a right knee sprain/strain as a result of the May 16, 2017 work-related accident. However, based on the opinions of

Dr. Bush-Joseph, the Arbitrator finds that Petitioner failed to prove that he is entitled to the prospective medical care recommended by Dr. Schafer.

Dr. Bush-Joseph based on his clinical examination of petitioner and review of petitioner's medical records including radiology imaging found that petitioner did not require further medical care for what injury he sustained to his right that was causally related to his work accident. Dr. Bush Joseph found petitioner's subjective complaints at the IME to be hysterical in nature, with no objective physical findings to support his subjective complaints. There was no tenderness, effusion, no joint line tenderness, and no physical findings.

Dr. Bush-Joseph interpreted Petitioner's right knee MRI as showing a chronic tear of the lateral meniscus, not the acute tear interpreted by Dr. Schafer. For reasons stated above Arbitrator finds Dr. Bush-Joseph's assessment of the MRI findings more persuasive than that of Dr. Schafer. In addition, Dr. Bush-Joseph noted inconsistencies during the IME when Petitioner was distracted. Therefore, based on Dr. Bush-Joseph's opinion, the Arbitrator finds that petitioner failed to prove that he was entitled to prospective medical treatment pursuant to §8(a) of the Act.



Steven J. Fruth, Arbitrator

April 6, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC017609
Case Name	URBINA, GILBERTO v. KING OF GLORY OF CHICAGO AKAR
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0196
Number of Pages of Decision	23
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Zachary Sims
Respondent Attorney	Dan Kallio

DATE FILED: 4/23/2021

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

Gilberto Urbina,

Petitioner,

vs. NO: 15 WC 17609

King of Glory of Chicago, a/k/a R & J Constructions,
a/k/a J & R Construction and Illinois State Treasurer,

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, temporary disability, and statute of limitations, 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, with the changes made below.

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of statute of limitations. The decision of the Arbitrator otherwise delineates the procedural and substantive history of Petitioner's claim.

In discussing the statute of limitations, the Arbitrator noted that neither Respondent King of Glory of Chicago nor Respondent Injured Workers' Benefit Fund (hereinafter "IWBF") raised the statute of limitations issue at any time prior to arbitration, during the hearing, or prior to closing proofs. The Arbitrator found that the IWBF had waived the right to assert a statute of limitations defense. Given the facts and circumstances of this case, the Commission disagrees.

In *Baldock v. Industrial Comm'n*, our supreme court addressed whether the limitations defense can be waived where a respondent fails to raise it until cross-examination and in the absence of a pre-hearing motion to dismiss, which was later filed, on that basis. *Baldock*, 63 Ill. 2d 124, 126-28 (1976). The court observed:

> "Although the question of when waiver of the defense of limitations occurs would appear to be quite simple, its difficulty is demonstrated by the fact that, in support of their respective positions, the parties cite the same authorities. (See *Lake State Engineering Co. v. Industrial Com*. (1964), 31 Ill.2d 440; *Railway Express Agency v. Industrial Com*. (1953), 415 Ill. 294; *Pocahontas Mining Co. v. Industrial Com*. (1922), 301 Ill. 462; *Tribune Co. v. Industrial Com*. (1919), 290 Ill. 402.) The rule, if any, which can be distilled from these cases is that whether there has been a waiver of limitations depends upon the particular facts of the case."

63 Ill. 2d at 127. The court noted that

> "Perhaps there are situations where the question of waiver is one of law, but on this record the question whether respondent waived its defense under section 6(c) of the Workmen's Compensation Act was one of fact for the Industrial Commission. In deciding the question the Industrial Commission was required to take into consideration the disputed stipulation and the conduct of the parties both before and after the motion to dismiss was filed. We are not prepared to say that its finding that there was no waiver was contrary to the manifest weight of the evidence. The judgment of the circuit court of Macon County is affirmed."

Id. at 127-128.

The IWBF argues on review that the Arbitrator erred in finding that it waived its right to argue the statute of limitations as a defense. As noted in the *Baldock* decision, whether a respondent can waive its right to assert that a claimant has failed to provide proper notice, and the associated statute of limitations defense, is a question of fact. Here, all issues were disputed by the IWBF including the date of accident and notice. Only on review of the Arbitrator's findings of fact and conclusions of law with respect to these issues can the Commission determine whether Respondent's now clearly asserted statute of limitations defense be analyzed. Accordingly, the Commission finds that the IWBF did not waive its right to assert a statute of limitations defense.

Nevertheless, the Commission agrees with the Arbitrator that the statute of limitations defense fails in this case. Workers' compensation proceedings are less formal than civil proceedings and amendments to applications are commonly allowed. See *Caterpillar Tractor Co. v. Industrial Comm'n*, 215 Ill. App. 3d 229, 238-39 (1991) (and cases cited therein). Indeed, amendments to pleadings are and should be liberally allowed and amended pleadings may be found to relate back to the original filings when that relation back does not prejudice the opposing party. The purpose of the relation back doctrine is to preserve causes of action against loss due to technical pleading rules and is satisfied where (1) that the original pleading was timely filed, and (2) that the cause of action asserted in the amended pleading grew out of the same transaction or occurrence. See, *e.g*., *Santiago v. E.W. Bliss Co*., 2012 IL 111792, ¶¶ 25-26 (discussing relation back under section 2-616(b) of the Illinois Code of Civil Procedure). In this

case, the Arbitrator correctly determined that the amended Application was timely filed and the amended pleading, like the original, related to the injury of Petitioner's pelvis at work. Thus, the amended complaint will relate back unless Respondent is unfairly prejudiced thereby. The basic policy of statutes of limitations is to afford a defendant a fair opportunity to investigate the circumstances upon which liability against it is predicated while the facts are accessible. *E.g.*, *Geneva Construction Co. v. Martin Transfer & Storage Co*., 4 Ill. 2d 273, 289-290 (1954). Here, the Arbitrator correctly determined that Respondent clearly was aware of the accident, the accident date, and the nature of the injury. Respondent defended the claim on the merits and identified no issue on which the passage of time had prejudiced its ability to do so. Accordingly, the Commission rejects the statue of limitations defense in this case.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020, is hereby affirmed and adopted, with the changes noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 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 shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,400.00. 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: **4/21/2021**
o: 3/4/21
BNF/wde
45

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION **21IWCC0196**
NOTICE OF ARBITRATOR DECISION

URBINA, GILBERTO Case# **15WC017609**
Employee/Petitioner

KING OF GLORY OF CHICAGO AKAR
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2520 ZACHARY K SIMS PC
2400 RAVINE WAY
SUITE 200
GLENVIEW, IL 60025

0000 KING OF GLORY OF CHICAGO AKAR
& J CONST AKA J&R CONSTRUCTION
4302 W MADISON ST
CHICAGO, IL 60624

6285 ILLINOIS ATTORNEY GENERAL OFFI
DANIEL KALLIO
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

Gilberto Urbina
Employee/Petitioner
v.
King of Glory of Chicago, a/k/a R&J Construction, a/k/a J&R Construction, and Illinois State Treasurer, as IWBF Custodian,
Employer/Respondent

Case # **15** WC **017609**

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 **Joseph D. Amarilio**, Arbitrator of the Commission, in the city of **Chicago**, on **March 10, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☒ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **N/A**

FINDINGS

On **August 29, 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 **$20,800.00**; the average weekly wage was **$400.00**.

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

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

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

Respondent shall be given a credit of **$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 **$22,765.30,** as provided in Sections 8(a) and 8.2 of the Act.

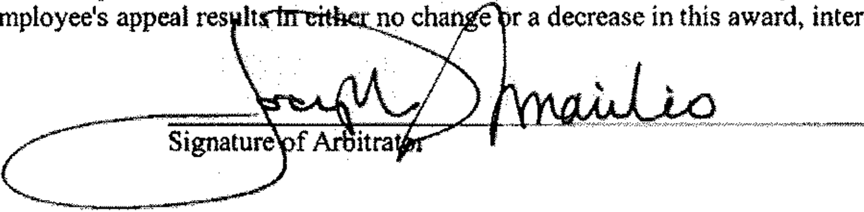
Respondent shall pay Petitioner temporary total disability benefits of **$266.67**/week for 17-2/7th weeks, commencing **08/30/2012** through **12/29/2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$253.00**/week for **75** weeks, because the injuries sustained caused the **15 %** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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



Signature of Arbitrator

4/13/2020
Date

APR 14 2020

ARBITRATION DECISION

ATTACHMENT

Gilberto Urbina v. Illinois State Treasurer, as IWBF Custodian, et al.
Case Number: 15 WC 17609

FINDINGS OF FACTS

Petitioner-Employee, Gilberto Urbina ("Petitioner"), brought this clam for benefits under the Illinois Workers' Compensation Act (the "Act") from the Respondent-Employer, King of Glory Chicago ("Respondent-Employer") and the Illinois State Treasurer as *Ex Officio* Custodian of the Injured Workers' Benefit Fund, ("IWBF").

On March 10, 2029, the arbitration hearing was conducted with the Petitioner as the only testifying witness. The Petitioner and Respondent IWBF were represented by their respective counsel. The Respondent-Employer, and its owner Rufas Jackson, did not appear and was not represented by counsel.

The Petitioner, Gilberto Urbina, testified that has been a manual laborer and painter for much of his adult life. Petitioner is currently 70 years old, not married, with no minor children. The Petitioner sustained an injury on August 29, 2012 when he fell off a ladder from a height of approximately 8 feet landing on his back.

Petitioner is currently 70 years old and lives in Chicago. Petitioner is not married and has no children. Petitioner testified that on August 29, 2012, he was employed by Respondent-Employer and the owner was Rufus Jackson ("Jackson"). Petitioner testified that Jackson owned and operated Respondent-Employer's business under several names including King of Glory of Chicago, and J&R Construction. Petitioner testified that all these entities are owned by Jackson. Respondent-Employer had two other employees.

Petitioner testified that he worked for Respondent-Employer for approximately ten years as a general laborer. His duties included general labor work such as carpentry, plumbing, and electrical work. This required the use of power tools. In addition, Petitioner engaged in roofing work which required sealing rooftops with rubber. Respondent-Employer was responsible for securing jobs and determined which days Petitioner would work, and what time work would begin and end. Petitioner was paid $400 per week in cash. Taxes and Social Security were not taken out. Petitioner testified that he was paid $400 per week, regardless of the number of hours, and worked five days a week. He would typically work between eight- and twelve-hour days. Petitioner did not sign an employment contract and no training was provided.

On the date of the incident, Petitioner was employed with King of Glory of Chicago, a/k/a R&J Construction, a/k/a J&R Construction. The employing entity was owned and operated by an individual named Rufus Jackson. On the date of the incident Petitioner was responsible for wide ranging duties including but not limited to manual labor, painting and roof work. Petitioner

testified that his job is a physically demanding job with duties that require heavy lifting, climbing ladders, and working on rooftops.

On August 29, 2012, Petitioner was climbing a ladder carrying a five-gallon bucket of roof sealant when the base of the ladder moved causing Petitioner to fall approximately 8 feet landing on his back. He immediately experienced intense pain in his pelvic area and an inability to stand and walk. Petitioner's co-workers immediately came to his aid. Mr. Rufus Jackson, owner of the company, also came to Petitioner's aid. Both petitioner's co-workers and Mr. Rufus Jackson tied petitioner to a makeshift dolly and wheeled petitioner to the work van and Mr. Jackson drove him home. Petitioner was then carried into his home and laid in his bed by his co-workers and Mr. Rufus Jackson. Petitioner laid in bed all night and was taken to University of Illinois Hospital Emergency Room the following day by a friend.

Petitioner presented to the emergency room on August 30, 2012, with complaints of pain in his pelvis. Diagnostic studies of the pelvis revealed a complex left acetabular fracture extending from inferior pubic ramus to the iliac bone. (PX1, P. 6-7). Petitioner did not undergo surgical intervention or casting. *Id.* Petitioner was admitted to the hospital and discharged on September 1, 2012.

Petitioner was unable to seek further treatment beyond that received at University of Illinois Hospital due to lack of workers' compensation insurance and health insurance Jackson provided Petitioner with a walker that he used for approximately one month. He then transitioned to crutches for approximately another two to three months following use of the walker. Petitioner testified that he was off work due to his injuries and did not work from August 29, 2012 and returned to work on or about December 29, 2012. Petitioner testified that he was not paid any TTD benefits while off work. After returning to work, Petitioner was having difficulty performing his duties and stated that his employer no longer gave him work and terminated him. Petitioner testified that he continues to have pain in his pelvic area. He has pain when he walks and is afraid of climbing ladders. Petitioner testified that before August 29, 2012 he hadn't previously injured his back or pelvis. He also testified that since August 29, 2012 he hasn't had any new injuries to his back or pelvis.

Petitioner incurred charges for medical services from University of Illinois Hospital and University of Chicago Physician's Group. The bill rendered by the University of Illinois Hospital indicates the amount billed as "bad debt/collection agent referral". The bill rendered by the University of Chicago Physician's Group indicates that the amount billed is "bad debt/written off."

Petitioner testified that following his discharge from the hospital he experienced an incredible amount of pain and discomfort, inability to ambulate, loss of range of motion and loss of strength in his pelvis area. He testified he was unable walk and could not sleep comfortably. He testified he would do his best to get up but stayed so many days in bed. After being bedridden for many days he was finally able to walk, but only with the aid of a walker. He used the walker for more than a month. After a month he was able to ambulate with crutches which he used for a long time. Petitioner also testified that following the injury he was completely unable to perform household activities, couldn't dress and undress himself, and he was unable to drive for a long time.

Petitioner testified he continues to experience pain, even to this day, approximately seven and a half years post-accident.

Petitioner testified that he continues to have pain in his pelvic area. He has pain when he walks and is afraid of climbing ladders. Petitioner testified that before August 29, 2012 he had not previously injured his back or pelvis. He also testified that since August 29, 2012 he hasn't had any new injuries to his back or pelvis.

Petitioner incurred charges for medical services from University of Illinois Hospital and University of Chicago Physician's Group. The bill rendered by the University of Illinois Hospital indicates the amount billed as "bad debt/collection agent referral". The bill rendered by the University of Chicago Physician's Group indicates that the amount billed is "bad debt/written off".

CONCLUSSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989). Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Petitioner testified in open hearing before the arbitrator who had opportunity to view his demeanor under direct examination and under cross-examination. The arbitrator evaluated the testimony of the Petitioner in consideration of all the evidence in the record. The arbitrator finds that Petitioner was a credible witness.

The threshold issue in this matter is whether the claim is timely. Section 6(d) of the Act states in pertinent part:

> "In any case, other than one where the injury was caused by exposure to radiological materials or equipment or asbestos unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred." 820 ILCS 305/6(d).

The original application in this case was filed on June 5, 2015. (See RX1). The original application alleged a date of injury of June 6, 2012. The Application For Adjustment of Claim alleged a right hip fracture. This application was timely filed.

On February 6, 2020, the original application was amended to reflect an injury date of August 29, 2012 to the left pelvis.

The Arbitrator notes that Petitioner was suffering from a left-hand infection caused by a fall on or about June 6, 2012. (See PX1, P. 149 *et seq.*).

Thus, the original application that was filed in this case originates from claimed an injury to his pelvis but incorrectly listed the date of accident as June 6, 2015 instead of August 29, 2012.

The Arbitrator is notes that amendments to pleadings are and should be liberally allowed and that amended pleadings may be found to relate back to the original filings. The substitution of dates in this action was made after the limitations period had expired did not prejudice the Respondent-Employer. Respondent-employer clearly was aware of the accident, the date of the accident and nature of the injury. The amended Application was filed to correctly state what the parties knew and did not attempt to substitute an entirely different injury in place of the original application.

Additionally, neither the Respondent-employer nor IWBF raised the issue of the statute of limitations. Neither the Respondent-employer nor the IWBF asserted that Petitioner's claim for benefits was time barred. It was not raised any time prior to trial or at the start of trial, during the trial, nor during the closing of proofs. The IWBF disputed every issue from A through N. It did not assert that the claim was time barred under disputed issue "O". marked "other " (Arb. Ex. 1; Tr. pp. 7-10) The Arbitrator, therefore, finds that the statute of limitations defense was and is waived.

Under these circumstances, the Arbitrator finds that Petitioner's claim is not barred. Therefore, the Arbitrator proceeds to address the disputed issues, A through N, noted below.

In regard to disputed issue A, "Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?", the Arbitrator finds as follows:

Section 3 of 820 ILCS 305, hereinafter referred to simply as "the Act" sets forth the following: The provisions of this Act hereinafter following shall apply automatically and without election to the State, county, city, town, township, incorporated village or school district, body politic or municipal corporation, and to all employers and all their employees, engaged in any department of the following enterprises or businesses which are declared to be extra hazardous, namely:

1. The erection, maintaining, removing, remodeling, altering or demolishing of any structure.
2. Construction, excavating or electrical work.

Petitioner testified that on the date of the accident, being August 29, 2012, he was employed by Mr. Rufus Jackson. (Tr. pp. 14-15). Mr. Rufus Jackson, as petitioner's employer, also went by the name of J&R Construction, R&J Construction and King of Glory of Chicago. (Tr. p. 15).

With regard to the duties Petitioner was typically responsible for performing as part of his employment prior to the date of the accident he testified:

Q: What were some of the duties that you would do prior to August 29, 2012?

A: We were doing roofing, you know, you put heat on the rubber and lay it down. Then
after that, we put some sealer, I think it's called Silver Sealer, you known, on top, so that the sun reflects the heat up, that's why they call it Silver Sealant.

Q: Was that similar type work that you would do before August 29, 2012, at other locations?

A: Well, usually we did carpentry work, there was some labor work, carpentry work, plumbing, electric work, you know. I think they did any kind of job, but at the time I was doing the job, I was doing roofing.

(Tr 18)

The nature of this work constitutes and is tantamount to that work described in 820 ILCS 305, Section 3(1) and (2).

Based on the above, the Arbitrator finds that on August 29, 2012 and for some time prior thereto, Respondent, King of Glory Chicago, was operating under and subject to the Illinois Workers' Compensation Act. Pursuant to Section 3 of the Illinois Workers' Compensation Act, the Act automatically applies to an Employer who meets any one of the seventeen listed "extra-hazardous" activities. Testimony at trial established that Respondent was engaged in construction and contracting. This falls under Subsection 15 as a "business or enterprise in which electric, gasoline or other power-driven equipment is used in the operation thereof." Therefore, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act on August 29, 2012

In support of disputed issue B, "Was there an employee-employer relationship?", the Arbitrator finds as follows:

The Workers' Compensation Act, 820 ILCS 305/1, hereinafter referred to simply as ("the Act") defines an employer as "any person or corporation, whether political, public, or private, that has any person in its employment and that has either elected to become subject to the Act, or is engaged in any activities or undertakings that are declared by the Act to be extra hazardous.

Section 1(b) of the Act sets forth that the term "employee" as used in this Act means (2) Every person in the service of another under any contract of hire, express or implied, oral or written, including persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made, and

including aliens, and minors who, for the purpose of this Act are considered the same and have the same power to contract, receive payments and give quittances therefor, as adult employees.

When considering whether one is an employee, it is necessary to consider a number of factors of evidentiary value, such as the right to control the manner in which work is done; method of payment; right to discharge; skill required in the work to be done; who provides tools, material, or equipment; whether the workmen's occupation is related to that of the alleged employer; and whether the alleged employer deducted withholding tax. The right to control work is the single most important of these factors. *Associates Corporation of North America v. Industrial Commission,* 167 Ill.App3d 988, 522 N.E.2d 102, 118 Ill.Dec. 647 (1st Dist. 1988).

Whether or not an employer-employee relationship exists is a question of fact and the Commission's determination will not be set aside unless contrary to the manifest weight of the evidence... The most important factor controlling this determination is the right to control the manner in which the work is don. Other factors with significant evidentiary value include method of payment; right to discharge; skill required in the work to be done; who provides tools, material or equipment; whether the worker's occupation is related to that of the alleged employer; and whether the alleged employer deducted for withholding tax. *Smokey Brothers, Inc. v. Industrial Commission*, 167 Ill.App.3d 910, 522 N.E.2d 278, 118 Ill.Dec. 823 (3rd Dist. 1988).

Petitioner testified that on the date of the accident, being August 29, 2012, he was employed by Mr. Rufus Jackson. (Tr. pp. 14-15). Mr. Rufus Jackson, as Petitioner's employer, also went by the name of J&R Construction, R&J Construction and King of Glory of Chicago. (Tr. p. 15).

The Arbitrator finds compelling Petitioner's unrebutted testimony. which set forth the following:

Petitioner's credible testimony makes clear that Petitioner considered himself an employee of Respondent, that he had been an employee of Respondent for ten years; Respondent provided transportation to Petitioner to each job site; Respondent was in control of obtaining work contracts with customers; Respondent provided supplies, tools and equipment for work to be performed; Respondent was in control of the work schedule and the manner in which the work was to be performed; Respondent had the authority to hire and fire; and Petitioner's employment with Respondent involved construction skills of which Petitioner had 60 years' experience.

Based upon Petitioner's unrebutted testimony, the Arbitrator finds there was an employee-employer relationship.

In support of the Arbitrator's decision relating disputed issue C, whether an accident occurred that arose out of and in the course of Petitioner's employment, the Arbitrator finds the following:

The Supreme Court has held that the word "accident" is not a technical legal term but encompasses anything that happens without design or any event that is unforeseen by the person to whom it happens. *E. Baggot Co. v. Industrial Commission*, 290 Ill.530 (1919). 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 the employment, unexpectedly, and without affirmative act or design of the employee. *Matthiessen & Hageler Zinc Co. v. Industrial Board,* 284 Ill.378, 120 N.E.

249, 251 (1918). An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp v. Industrial Commission*, 58 Ill.2d 226 (1974); *Warren v. Industrial Commission*, 61 Ill.2d 373 (1975).

Petitioner testified that on the date of the accident, being August 29, 2012, he was employed by Mr. Rufus Jackson. (Tr. ppp. 14-15). Mr. Rufus Jackson, as Petitioner's employer, also went by the name of J&R Construction, R&J Construction and King of Glory of Chicago. (Tr. p. 15).

On August 29, 2012, Petitioner was doing roofing work which included applying heat on the rubber and laying it down, then applying sealant. (Tr. pp. 17 -18).

Specifically, on the morning of August 29, 2012, petitioner was in the process of ascending a ladder to the second floor of the property. (Tr. pp. 22-23). He testified as follows:

> Q: And your job was to get up to the second level?
> A: Yes. I was on the first level. So when I get on the ladder, put it on with five gallons of liquid, chemical liquid, I was going to the second level. That's when the ladder slide down, and I fall on my back.
> Q: Okay. How far did you fall?
> A: From eight feet, something like that, yes.
> Q: What part of your body struck the ground?
> A: Well, my pelvis, back

(Tr., pp. 22-23)

Petitioner further testified that he had never previously injured his pelvis or back before and had not sustained any subsequent or new injury. (See hearing transcript page 24).

Petitioner's testimony that the injury occurred on August 29, 2012, while performing the duties of his employment, and while ascending a ladder and falling from said ladder, is unrebutted.

Based upon petitioner's unrebutted testimony, the Arbitrator finds that the accident that occurred arose out of and in the course of Petitioner's employment by respondent.

Based upon Petitioner's unrebutted testimony, the Arbitrator finds that the Respondent was provided and had timely notice of the accident.

In support of the Arbitrator's decision relating disputed issue D, relating to the date of accident, the Arbitrator finds the following:

Petitioner's unrebutted testimony confirmed Petitioner went to work for Respondent on August 29, 2012 and was injured while doing roofing and sealing work on that day. (See hearing transcript page 18). Petitioner showed up for work at 7:00 a.m. (Tr. p. 18). The work site was located at Douglas and Kedzie, at a Christian school, in Chicago. (Tr. p. 18). The weather that day was a sunny day. (Tr. p 22).

Based upon Petitioner's unrebutted testimony and the evidence as a whole, the Arbitrator finds that the date of accident was August 29, 2012.

In regard to disputed issue E, whether timely notice of the accident was provided, the Arbitrator finds the following:

Petitioner's unrebutted testimony confirms that Respondent was immediately "on notice" of Petitioner's accident.

Referring to who came to his aid following the accident on the date of August 29, 2012, Petitioner testified as follows:

Q: So after you fell, who came to your assistance?
A: I had to stay there for a while until Mr. Rufus came by, and they dragged me with piece of material all the way to the edge of the roof, and tied me with some kind of a dolly,tie me, and they bring me down to the ground.
Q: And so Mr. Rufus Jackson was aware of what happened to you that day; is that correct?
A: Yes, he was not over there, but he was at another job, and then when he came, he took
maybe an hour, I was still on the ground, I mean, on the roof, I couldn't get up.
Q: You saw Mr. Jackson when he arrived that morning?
A: Yes
Q: And you told him what happened?
A: Yes, yes.

(Tr. p. 25).

In support of the Arbitrator's decision relating to disputed issue F, whether the Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Petitioner fell off a ladder from a height of approximately 8 feet. Immediately following the fall Petitioner was in pain and unable to stand. While lying on the ground Petitioner's co-employees and Mr. Rufus Jackson attended to him. Mr. Rufus Jackson and Petitioner's co-employees tied Petitioner to a dolly and wheeled him to the work van. Mr. Rufus Jackson and Petitioner's co-employees drove Petitioner home and carried him from the van to his bed.

The following day Petitioner was examined at University of Illinois Medical Center. Emergency room records confirm that Petitioner fell 8 feet from a ladder to his back. (See Petitioner exhibit #1, page 24/904). Nurse triage notes indicate that Petitioner fell off an 8-foot ladder and was complaining of left hip pain and that he was not able to ambulate. (See PX1, page 44/904). X-rays were taken which revealed two radiolucent lines seen within the left iliac bone and a fracture through the inferior ramus of the left pubic bone. (PX1, p. 6/904). A CT scan further confirmed a complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone and associated hematoma formation within the left obturator internus muscle and presacral region. (PX 1)

Petitioner testified that before August 29, 2012 he had never previously injured his pelvis. (Tr. p. 24). He also testified that since August 29, 2012, up until today, he hasn't had any new injuries to his back or pelvis. (Tr. p. 24).

The Arbitrator finds Petitioner's testimony persuasive and compelling. Petitioner provided unrebutted testimony that he fell from a ladder at a height of 8 feet and landed on his back. Petitioner's unrebutted testimony further confirmed immediate pain in the pelvic area. His testimony also revealed that he was immediately observed, by Mr. Rufus Jackson and co-employees, on the ground, in pain, and unable to get to stand. He testified as to his medical care and treatment. He testified that he continues to experience pain and discomfort in his left pelvic area.

Based upon the Petitioner's unrebutted testimony as well as the medical records entered into evidence as Petitioner's exhibit #1, the Arbitrator finds that the Petitioner did indeed sustain his burden in establishing that his current condition of ill-being with respect to his left pelvic region is causally related to his work injury of August 29, 2012.

In support of the Arbitrator's decision relating disputed issue G. Petitioner's earnings, the Arbitrator finds the following:

The Act defines average weekly wage as "the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52." 820 ILCS 305/10

In this case, the only evidence presented to demonstrate an average weekly wage is the testimony of Petitioner indicating a weekly wage of $400 in cash regardless of hours worked and that he worked 8 to 12 hours per day for the year proceeding the injury. (Tr. pp, 33-36), While the Arbitrator notes the lack of any corroborating evidence, Petitioner's testimony was unrebutted and credible.

The Arbitrator finds that Petitioner was earning $400.00 per week and had an average weekly wage of $400.00 in accordance with Section 10 of the Act.

In support of the Arbitrator's decision relating disputed issue H, Petitioner's age at the time of accident, the Arbitrator finds the following:

The Petitioner testified that he was born on August 3, 1949. Petitioner testified credibly and it has not been disputed with credible evidence. The Arbitrator finds that the Petitioner was 63 years of age at the time of the accident.

In support of the Arbitrator's decision relating disputed issue I, Petitioner's marital status at the time of accident, the Arbitrator finds the following:

Petitioner's unrebutted testimony confirms that Petitioner was not married at the time of the accident. (Tr. p. 14). Based upon Petitioner's unrebutted testimony, the Arbitrator finds that the Petitioner was not married on the date of accident.

In support of the Arbitrator's decision relating to disputed issue J, whether or not the medical services that were provided to Petitioner were reasonable and necessary, and as to whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

On August 30, 2012, Petitioner was examined and evaluated for injury at the University of Illinois Medical Center emergency department. He was assessed with sustaining a pelvic and/or hip fracture. Petitioner underwent diagnostic studies which revealed a complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone. Petitioner was admitted to the University of Illinois Medical Center on August 30, 2012 and remained hospitalized until his discharge on September 1, 2012. (Px 1).

Based upon Petitioner's unrebutted testimony, the Arbitrator finds that given the critical nature of the trauma sustained by Petitioner as a result of his 8 foot fall off the ladder on August 29, 2012, and given the diagnosis of a complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone, the emergency room care and treatment, diagnostic radiology, admission to the University of Illinois Medical Center, and all medical services provided to Petitioner as set forth in the medical records admitted as Petitioner's Exhibit #1, through the date of discharge from the University of Illinois Medical Center, were reasonable and necessary.

The Arbitrator finds that the medical services rendered to Petitioner by the University of Illinois Medical Center, for dates of service August 30, 2012 through September 1, 2012, resulting in charges in the amount of $21,302.30, as set forth in Petitioner's exhibit #3, were based upon reasonable and necessary medical services provided. Said amount is awarded to Petitioner pursuant to the fee schedule.

The Arbitrator finds that the medical services rendered to Petitioner by the UIC Physician Group, for dates of service August 30, 2012 through September 1, 2012, resulting in charges in the amount of $1,463.00, as set forth in Petitioner's exhibit #2, were based upon reasonable and necessary services provided. Said amount is awarded to Petitioner pursuant to the fee schedule.

The Arbitrator further finds that the Respondent did not pay any appropriate charges for reasonable and necessary medical services noted above.

In support of the Arbitrator's decision relating to disputed issue K, whether there is an amount of compensation due to Petitioner for temporary total disability, the Arbitrator finds the following:

Petitioner's first day of lost time was the date of the accident, being August 29, 2012. He testified that at the time of the injury he was earning $400.00 per week. (Tr. p. 33). He testified that he was earning $400.00 per week for at least the 52 weeks preceding the date of the accident. (Tr. p. 34). Petitioner was unable to work any other jobs during the 6 months he was unable to work for Respondent. (Tr. p. 33).

Petitioner was not paid any disability benefits from August 29, 2012 to and through December 29, 2012, during which time he was unable to work. (Tr. p. 33).

It is unrebutted that Petitioner suffered a complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone. Although Petitioner did not undergo surgery or pursue out-patient physical therapy, he was in fact home bound and unable to work for an extended period of time). Medical records from the University of Illinois Medical Center document that Petitioner needed to see a traumatologist but there was no traumatologist on staff at UIC and that Petitioner will likely need around 2 months of non-weight bearing on the left. (See Petitioner's exhibit #1, page 98/904). Petitioner testified that following discharge from the hospital he spent months utilizing a walker and then crutches. (Tr. p. 30). Petitioner testified that as of the date of the hearing (March 10, 2020) he was still in pain. (Tr. pp. 31-32).

Petitioner returned to work on December 29, 2012 but retired shortly thereafter.

Based upon Petitioner's unrebutted testimony, as well as the medical records entered into evidence as Petitioner's exhibit #1, the Arbitrator finds that Petitioner was temporarily totally disabled from August 29, 2012 through December 29, 2012 representing 26 weeks. The arbitrator further finds that Petitioner was not paid any temporary total disability by Respondent.

Respondent shall pay Petitioner temporary total disability benefits of $266.67/week for 17-2/7th weeks, totaling $4,609.58, for the period of August 30, 2012 through December 28, 2012 as provided in Section 8(b) of the Act. Petitioner's average weekly wage, calculated pursuant to Section 10 of the Act, was $400.00

In support of the Arbitrator's decision relating to disputed issue L, nature and extent of the injury, the Arbitrator finds the following facts:

Petitioner, Gilberto Urbina, a manual laborer, painter and roofer, employed with Respondent, sustained an injury on August 29, 2012, when he fell 8 feet to the concrete landing on his back.

On August 30, 2012, Petitioner was examined and evaluated for injury at the University of Illinois Medical Center. He was assessed with sustaining a pelvic and/or hip fracture. Petitioner underwent diagnostic studies which revealed a complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone. Petitioner was admitted to the University of Illinois Medical Center on August 30, 2012 and remained hospitalized until his discharge on September 1, 2012. (See medical records dated 8/30/2012 – 9/1/2012 in Petitioner's exhibit #1).

Petitioner testified that upon discharge he returned home. He did not undergo surgery or physical therapy. Petitioner testified that "they didn't send me for physical therapy. They just tried to make me get up and start walking, you know, slowly and slowly, but I couldn't make it. It was so hard, painful. Petitioner testified that he was unable to walk and was bedridden for many days. He was only able to get up with the use of a walker which he used for over a month. (Tr. p. 30).

Following a month or more of using a walker he was able to ambulate using crutches, which he used for a long time, many, many weeks or month". (Tr. pp. 30-31). Petitioner testified that during his recovery he was unable to work and was stuck at home. Petitioner further testified that even now, approximately 7 ½ years following the accident, he is still in pain. (Tr. pp. 31-

32). He testified "I cannot stay sit down for many, many hours. It is very hard to get up. When I try to start walking, I feel pain. After some time, I start walking better, you know, but I'm still in pain". (Tr. pp. 31-32). Referring to his ability to do things at home after the accident Petitioner testified that in the first few months, he could not do anything, sleeping was difficult, and he could not drive. (Tr. 32). He testified he couldn't do any household activities and was having difficulty getting dressed and undressed. (See hearing transcript page 33).

Prior to the accident Petitioner had been employed as a construction laborer, painter and roofer. The nature of this type of employment required Petitioner to physically exert himself to a great extent, including carrying and lifting heavy objects, long hours on his feet, climbing ladders, and bending and stretching. Upon arbitrator questioning, Petitioner testified that he still has pain and that movement causes pain. (Tr. p. 37). He testified that walking is painful and that although he could climb a ladder, he is now afraid to do so. (Tr. p. 38). He testified that he has not gone back to work since returning to work in December 2012 because he "could not work as usual, at that time". (Tr. p. 38).

In determining the nature and extent of the Petitioner's injuries, the arbitrator has considered the 5 factors as required by statute.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a laborer at the time of the accident performing medium to heavy labor. He attempted to return to work but was unable to perform his duties as before. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 63 years old at the time of the accident. Because of his injury is more disabling at his age, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner attempted to return to work but was unable to perform his duties due to his injury. He was terminated because he could not able to do his usual work duties. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes sustained complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone and associated hematoma formation within the left obturator internus muscle and presacral region for which Petitioner received the bare minimum medical care due to lack of insurance. Because of the nature of the injury and the lack of medical care, 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 a disabling condition resulting from a complex left acetabular fracture extending from the inferior pubic ramus to the iliac bone for which Petitioner received minimal medical care, the

disabling condition is permanent partial disability pursuant to Section 8(d)(2) of the Act and that Respondent shall pay the Petitioner permanent partial disability benefits of $18,000.00 which represents 15% man as a whole at $240.00/week for a period of 75 weeks.

In support of the Arbitrator's decision as to disputed issue N, whether Respondent is due any credit, the Arbitrator finds the following:

Respondent has not paid any benefits to Petitioner. As such, the Arbitrator finds that Respondent is not due any credit.

The Illinois State Treasurer as ex officio custodian of the IWBF was named as a party respondent in this matter. Petitioner submitted sufficient credible evidence that Respondent-Employer was not insured at the time of the injury. Such evidence consisted of the National Council on Compensation Insurance Certificate. Further, Petitioner provided sufficient credible evidence that notice of the proceedings were provided to the Respondent-Employer as Respondent-Employer was represented at hearing.
This finding is hereby entered as to the IWBF to the extent permitted and allowed under §4(d) of the Act. Should any recovery by the Petitioner occur, Respondent-Employer shall reimburse IWBF for any compensation obligations of Respondent-Employer that are paid to the Petitioner from IWBF, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC027045
Case Name	BELLANTE, ROBERTA v. KD TRANSPORT INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0197
Number of Pages of Decision	15
Decision Issued By	Stephen Mathis, Commissioner,

Petitioner Attorney	Christopher Williams
Respondent Attorney	Jill Otte, State of Illinois Attorney General, Office of the Attorney General

DATE FILED: 4/23/2021

/s/ *Stephen Mathis, Commissioner*

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roberta Bellante,

Petitioner,

vs. No. 08 WC 27045

KD Transport, Inc., Kevin R. Daniels, and
Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issues of notice, wage calculations, benefit rates, temporary disability and permanent disability, and being advised of the facts and law, corrects, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the Arbitrator's Decision to: reflect the surgery took place in January of 2009, not 2019 (page 5); end temporary total disability benefits on May 20, 2009, not 2019; and convert the permanent partial disability award to 10.12 percent disability to the person as a whole, as the injury was to the shoulder.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 3, 2019, is hereby corrected, affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondents 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 $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.

APRIL 23, 2021

/s/*Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-4/7/2021
44

/s/*Deborah Baker*
Deborah Baker

/s/*Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELLANTE, ROBERTA
Employee/Petitioner

Case# **08WC027045**
08WC043830

KD TRANSPORT INC KEVIN DANIELS & IWBF
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:

5122 PORRO NIERMANN LAW GROUP LLC
CHRIS M WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

0000 KD TRANSPORT INC
KEVIN DANIELS
3234 211TH PL
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4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Roberta Bellante
Employee/Petitioner

v.

KD Transport, Inc., Kevin Daniels & IWBF
Employer/Respondent

Case # **08** WC **27045**

Consolidated cases: **08 WC 43830**

An *Application for Adjustment 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 **New Lenox**, on **7/8/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/8/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**1,000.00**; the average weekly wage was $**1,000.00**.

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

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

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

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

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,274.00 to Athletico, $39,351.12 to Provena Mercy Center, $2,036.00 to Rush Copley, and $2,890.00 to Hinsdale Orthopaedics, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $666.67/week for 66 3/7 weeks, commencing 2/9/08 through 5/20/19, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

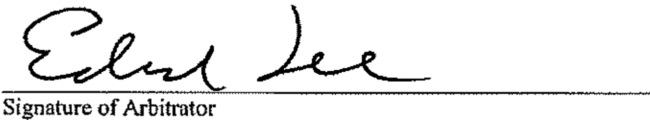
Respondent shall pay Petitioner permanent partial disability benefits of $600.00/week for 50.6 weeks, because the injuries sustained caused the 20% loss of the Right Arm, as provided in Section 8(e) of the Act.

Injured Workers' Benefit Fund

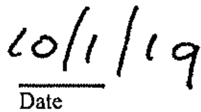
The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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



Signature of Arbitrator



Date

OCT 3 - 2019

Roberta Bellante v. KD Transport, Inc., Kevin Daniels, & IWBF
08 WC 27045
08 WC 43830

Petitioner's Proposed Findings of Facts and Conclusions of Law

Petitioner testified that on February 8, 2008, she worked for KD Transport. She testified that Kevin Daniels was the owner of KD Transport and that she was referred to KD Transport by Kevin Daniels' nephew. She knew that Kevin Daniels was the owner of the company because he represented himself as such. She testified that she began working for KD Transport as a truck driver on February 1, 2008. She testified that prior to starting at KD Transport she worked for a temporary company also as a truck driver. She testified that she signed an employment contract (PX9) on February 1, 2008. She testified that she was expected to make $1,000 per week with KD Transport as a driver.

Petitioner testified that while driving for KD Transport, she drove a truck owned by KD Transport and that the truck had a logo on both sides that said 'KD Transport.' She testified that when she arrived at her destinations, she identified herself as a driver for KD Transport. She testified that her deliveries and pickups were assigned by KD Transport and that Kevin Daniels called her on her cell phone to tell her where to go. She testified that she did not offer her services to any other trucking company while employed by KD Transport.

Petitioner testified that she did receive one paycheck from KD Transport and that taxes were deducted from that paycheck. She could not recall whether she received tax forms at the end of the year from KD Transport and did not have a copy of the paycheck or tax returns.

Petitioner testified that on February 1, 2008, she was assigned a delivery to Miami, Florida. She testified that she was hauling corned beef and made four stops in Florida. She testified that her truck was then loaded with potatoes and she headed back north to Illinois. She testified that near Atlanta, Georgia, she noticed that all of her gauges were high so she called Kevin Daniels and reported this incident. She continued traveling to Illinois. She testified that she delivered the potatoes to Chicago and was instructed by Kevin Daniels to pick up another load from cold storage in Minooka, Illinois.

Petitioner testified that she arrived to Minooka on February 8, 2008 and that she docked her truck. While she was waiting for her truck to be loaded, she moved to the sleeper section of her truck to take a nap. She testified that she was awoken to a funny smell. She opened the curtains and noticed that the engine of the truck was on fire. She testified that she attempted to get out of the driver's side door, but that the flames were too big, so she exited the vehicle from the passenger side door. She testified that she grabbed onto the safety bar with her right hand and jumped out. She testified that she felt pain in her right shoulder following the jump and grab onto the bar. Petitioner presented photographs of the truck following the fire as group exhibit PX16.

Petitioner testified that she called Kevin Daniels immediately and informed him that the truck had caught on fire. She testified that he did not return further calls. She testified that within 45 days, she wrote Kevin Daniels a letter explaining that she injured her shoulder when she jumped out of the truck. She also wrote Kevin Daniels with an itemized list of her belongings that were destroyed by the fire.

Petitioner testified that she treated at Rush Copley, Castle, Midwest Orthopaedics, Athletico, Mercy Hospital, and Hinsdale Orthopaedics. She testified that she had surgery in January 2009 and that she was released to full duty on May 20, 2009. She testified that between February 9, 2008 and May 20, 2009, she did not work because of her shoulder and that she did not receive any benefits.

She testified that prior to this accident, she had never injured her right shoulder before. She testified that since the accident, her right shoulder is more arthritic than her left shoulder. She testified that the strength in that shoulder is gone. She testified that she retired in 2012.

Petitioner submitted an Illinois Secretary of State Corporation File Detail Report indicating that Respondent KD Transport, Inc. is an active Illinois Corporation (PX10). Petitioner submitted evidence that she notified Respondents of the hearing date through certified mail to KD Transport, Inc. in Lynwood, IL, Kevin Daniels in Doltin, IL, and to Kevin Daniels' bankruptcy attorney in Chicago, IL (PX14, PX15). Additionally, Petitioner entered into evidence proof that Kevin Daniels had filed for bankruptcy personally in 2017 (PX11 and PX12). Petitioner further entered an order from the Northern District of Illinois Bankruptcy Court dated March 21, 2019 lifting the automatic stay so that Petitioner may pursue her workers' compensation claim (PX13).

Petitioner submitted certifications of non-insurance from NCCI (PX7 and PX17). The first is dated February 6, 2016 regarding KD Transport, Inc. in Lynwood, IL (PX7). The second is dated September 26, 2019 and references both Kevin Daniels and KD Transport, Inc. in Dolton, IL (PX17).

Medical Summary

Petitioner presented to Rush Copley's emergency department on June 4, 2008 (PX1 pg. 27). She provided a history of jumping out of a burning truck in February and having right arm pain ever since (PX1 pg. 27). She was diagnosed with a possible rotator cuff tear and advised to follow up with ortho (PX1 pg. 25).

Petitioner visited Dr. Steven Chudik at Hinsdale Orthopaedics on June 17, 2018 (PX8 pg. 2). Petitioner provided a history of jumping out of a burning truck and grabbing onto a rod on the outside of the truck causing her right arm to go into forced flexion and external rotation (PX8 pg. 2). She complained of immediate pain which has persisted (PX8 pg. 2). Dr. Chudik recommended an MRI and opined that Petitioner's shoulder injury was due to the work-related accident on February 8, 2008 (PX8 pg. 4).

Petitioner underwent an MRI on her right shoulder on June 21, 2008 (PX8 pg. 5). The MRI revealed a full-thickness rotator cuff tear (PX8 pg. 5). She returned to Dr. Chudik on June 23, 2008 and he recommended a right rotator cuff repair and distal clavicle resection (PX8 pg. 6).

He placed her on work restrictions of van driving with no lifting or repetitive use of the right upper extremity (PX8 pg. 6).

Petitioner returned to Rush Copley's emergency department for her right shoulder on November 3, 2008 (PX1 pg. 47). She was placed off of work until re-evaluated (PX1 pg. 49).

Petitioner presented to Dr. Paul Witt at Castle Orthopaedics on December 10, 2008 (PX2 pg. 32). She complained of shoulder pain that started in February 2008 (PX2 pg. 32). He referred her to Dr. Saleem for repair of the rotator cuff (PX2 pg. 32). She first visited Dr. Saleem on December 18, 2008 and he ordered the surgery (PX2 pg. 30-31).

Petitioner underwent surgery at Mercy Medical Center on January 12, 2009 (PX5 pg. 10-12). Dr. Saleem performed arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle excision (PX5 pg. 10). She followed up with Dr. Saleem on January 29, 2009 and was ordered to physical therapy (PX2 pg. 22).

Petitioner began physical therapy at Mercy Medical Center on February 9, 2009 (PX5 pg. 54). She completed a total of 11 visits from February 9, 2009 to April 30, 2009 (PX5 pg. 64).

Petitioner followed up with Dr. Saleem on February 19, 2009 and March 27, 2009 complaining of pain (PX2 pg. 16-19). On March 27, 2009, Petitioner complained of neck pain radiating down between her shoulder blades (PX2 pg. 16). Dr. Saleem ordered a cervical MRI (PX2 pg. 16). She returned on May 1, 2009 and had not yet had the MRI (PX2 pg. 12). On May 19, 2009, Dr. Saleem opined that her neck pain was unrelated to her rotator cuff and referred her to pain management (PX2 pg. 9-10). He also discharged her from care for her shoulder (PX2 pg. 10).

Petitioner presented to Dr. Tony Choi at MOI on April 4, 2015 (PX3 pg. 57). She was complaining of pain in her right shoulder following the surgery from 2008 (PX3 pg. 57). Dr. Choi ordered physical therapy and offered an injection, but Petitioner declined (PX3 pg. 57). Petitioner underwent physical therapy with Athletico from April 21, 2015 through July 30, 2015 for a total of 27 sessions (PX4).

Petitioner returned to Dr. Choi on April 23, 2015 and an MRI was ordered for her right shoulder (PX3 pg. 56). She had the MRI and returned to Dr. Choi on June 15, 2015 (PX3 pg. 54). At that visit, Dr. Choi noted that her MRI revealed thinning of the rotator cuff and that it is possible that the initial repair did well, but has degenerated over time (PX3 pg. 54). He also noted that she may have only had partial healing of the original repair (PX3 pg. 54). Dr. Choi discussed possible surgery and injections, but released Petitioner at that time (PX3 pg. 54).

Petitioner returned to Dr. Choi on July 11, 2017 (PX3 pg. 15). Petitioner indicate that the pain went away in 2015, but has reappeared in a similar way to the original rotator cuff tear (PX3 pg. 15). She returned to MOI on February 5, 2018 also complaining of right shoulder pain (PX3 pg. 1-3). She was diagnosed with right shoulder pain and physical therapy was ordered, but not completed (PX3 pg. 3).

Petitioner submitted the following medical expenses as a result of this treatment:

1)	Athletico	$6,274.00
2)	Provena Mercy Center	$39,351.12
3)	Rush Copley	$2,036.00
4)	Hinsdale Orthopaedics	$2,890.00
	Total	$50,551.12

Conclusions of Law

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

Respondent was operating a business covered by the Workers' Compensation Act at the time of the accident as a carrier of goods and additionally as a business using gasoline powered equipment. The arbitrator finds that Respondent was operating under and is subject to the Illinois Workers' Compensation Act.

B. Was there an employee-employer relationship?

Petitioner signed a wage agreement with Respondent and drove Respondent's truck. The truck she drove was labeled as Respondent's truck and she identified herself as a driver or Respondent. Respondent assigned the routes that Petitioner drove. The arbitrator finds that an employee-employer relationship existed between Petitioner and Respondent on the date of accident. Respondent exercised significant control over Petitioner's work and Petitioner did not hold herself out to work for anyone other than Respondent during her brief tenure.

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

Petitioner was waiting in her truck for it to be loaded when the truck started on fire. Petitioner was clearly in the course of her employment as she was in the process of making a delivery. The truck fire required Petitioner to escape from the truck as fast as possible and jump down out of danger. The risk of having to escape from a burning vehicle is one that is inherent to Petitioner's employment with Respondent. The arbitrator finds that Petitioner suffered an accident arising out of and in the course of her employment when she injured her shoulder jumping from a burning truck.

D. What was the date of the accident?

The date of the accident is February 8, 2008 as evidenced by Petitioner's testimony and corroborating medical records.

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

Petitioner testified that she provided verbal notice of the accident to Respondent. She also testified that within 45 days of the accident she also sent written notice of the accident to Respondent. As a result, the arbitrator finds that Petitioner gave timely notice of the accident to Respondent.

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

Petitioner suffered a torn rotator cuff in her right shoulder. This is the same arm she used to hold onto the safety bar as she jumped from the truck. Petitioner testified that she had no injuries to her right shoulder prior to this accident. Furthermore, Petitioner's treating physician, Dr. Chudik, opined that her condition was causally connected to the accident. The arbitrator notes the significant force applied to Petitioner's shoulder during her accident and, absent any evidence to the contrary, finds that Petitioner's right shoulder condition is causally related to her injury.

G. What were Petitioner's earnings?

Petitioner testified that she expected to earn $1,000.00 per week while working with Respondent. Petitioner stipulated that her average weekly wage was $1,000.00 per week. The arbitrator notes that in her wage agreement and pay scale with Respondent (PX9), Petitioner is set to be paid at $1.50 per mile. This is equivalent to 666.67 miles. The arbitrator notes that Petitioner traveled from Illinois to Florida and back in the one week before she was injured. This is much further than 666.67 miles.

As there was no other evidence and Petitioner stipulated to $1,000.00, the arbitrator finds that Petitioner's average weekly wage when she was injured was $1,000.00.

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

Petitioner was 52 years old at the time of the accident.

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

Petitioner was single 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?

Petitioner underwent a rotator cuff repair in January 2019 following her injury. She was also treated with physical therapy. In 2015, Petitioner sought additional treatment for her right shoulder as a follow up to the surgery. She was treated with physical therapy and was eventually released from care in 2015. The arbitrator notes that surgery and physical therapy are common, reasonable methods for treatment of Petitioner's injuries. The arbitrator finds that these medical services were reasonable and necessary.

Petitioner presented evidence of medical expenses incurred that have no been paid by Respondent. The arbitrator finds these expenses reasonable and necessary. These expenses total $50,551.12 and are subject to fee schedule reductions.

K. What temporary benefits are in dispute? TTD?

Petitioner testified that she was off of work following the injury until May 20, 2009 when she was released to full duty by Dr. Saleem following the January 12, 2009 surgery. Prior to the full duty release, she was on work restrictions that were never accommodated by Respondent. She

testified that she did not work from the time of the accident until May 20, 2019, a total of 66 3/7 weeks. The arbitrator finds that Petitioner was temporarily totally disabled for this period of time and 66 3/7 weeks of TTD benefits are due to Petitioner.

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

Petitioner suffered a full thickness rotator cuff tear that required surgery. She continued to have problems in 2015 where an MRI revealed thinning of the repaired rotator cuff. Petitioner testified that she did not have any issues with her right shoulder prior to this accident. She testified that she is more arthritic in the right shoulder following the accident. Petitioner did retire from driving in 2012.

The arbitrator finds that Petitioner is permanently partially disabled to the extent of 20% loss of use of the right arm.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC043830
Case Name	BELLANTE, ROBERTA v. KEVIN R DANIELS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0198
Number of Pages of Decision	15
Decision Issued By	Stephen Mathis, Commissioner,

Petitioner Attorney	Christopher Williams
Respondent Attorney	Ana Vazquez Illinois Attorney General

DATE FILED: 4/23/2021

/s/ *Stephen Mathis, Commissioner*

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☒ Injured Workers' Benefit Fund (§4(d))
	) SS.	☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILL	)	☐ 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

Roberta Bellante,

Petitioner,

vs. No. 08 WC 43830

KD Transport, Inc., Kevin R. Daniels, and
Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issues of notice, wage calculations, benefit rates, temporary disability and permanent disability, and being advised of the facts and law, corrects, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the Arbitrator's Decision to: reflect the surgery took place in January of 2009, not 2019 (page 5); end temporary total disability benefits on May 20, 2009, not 2019; and convert the permanent partial disability award to 10.12 percent disability to the person as a whole, as the injury was to the shoulder.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 3, 2019, is hereby corrected, affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondents 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 $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.

APRIL 23, 2021

/s/*Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-4/7/2021
44

/s/*Deborah Baker*
Deborah Baker

/s/*Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELLANTE, ROBERTA
Employee/Petitioner

Case# **08WC027045**

08WC043830

KD TRANSPORT INC KEVIN DANIELS & IWBF
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:

5122 PORRO NIERMANN LAW GROUP LLC
CHRIS M WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

0000 KD TRANSPORT INC
KEVIN DANIELS
3234 211TH PL
LYNWOOD, IL 60411

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
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

Roberta Bellante
Employee/Petitioner

v.

KD Transport, Inc., Kevin Daniels & IWBF
Employer/Respondent

Case # **08** WC **27045**

Consolidated cases: **08 WC 43830**

An *Application for Adjustment 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 **New Lenox**, on **7/8/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/8/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**1,000.00**; the average weekly wage was $**1,000.00**.

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

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

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

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

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,274.00 to Athletico, $39,351.12 to Provena Mercy Center, $2,036.00 to Rush Copley, and $2,890.00 to Hinsdale Orthopaedics, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $666.67/week for 66 3/7 weeks, commencing 2/9/08 through 5/20/19, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $600.00/week for 50.6 weeks, because the injuries sustained caused the 20% loss of the Right Arm, as provided in Section 8(e) of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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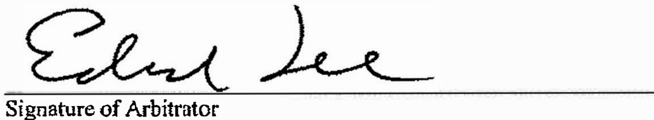
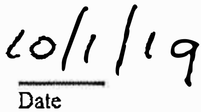


Signature of Arbitrator



Date

OCT 3 - 2019

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Petitioner testified that she treated at Rush Copley, Castle, Midwest Orthopaedics, Athletico, Mercy Hospital, and Hinsdale Orthopaedics. She testified that she had surgery in January 2009 and that she was released to full duty on May 20, 2009. She testified that between February 9, 2008 and May 20, 2009, she did not work because of her shoulder and that she did not receive any benefits.

She testified that prior to this accident, she had never injured her right shoulder before. She testified that since the accident, her right shoulder is more arthritic than her left shoulder. She testified that the strength in that shoulder is gone. She testified that she retired in 2012.

Petitioner submitted an Illinois Secretary of State Corporation File Detail Report indicating that Respondent KD Transport, Inc. is an active Illinois Corporation (PX10). Petitioner submitted evidence that she notified Respondents of the hearing date through certified mail to KD Transport, Inc. in Lynwood, IL, Kevin Daniels in Doltin, IL, and to Kevin Daniels' bankruptcy attorney in Chicago, IL (PX14, PX15). Additionally, Petitioner entered into evidence proof that Kevin Daniels had filed for bankruptcy personally in 2017 (PX11 and PX12). Petitioner further entered an order from the Northern District of Illinois Bankruptcy Court dated March 21, 2019 lifting the automatic stay so that Petitioner may pursue her workers' compensation claim (PX13).

Petitioner submitted certifications of non-insurance from NCCI (PX7 and PX17). The first is dated February 6, 2016 regarding KD Transport, Inc. in Lynwood, IL (PX7). The second is dated September 26, 2019 and references both Kevin Daniels and KD Transport, Inc. in Dolton, IL (PX17).

Medical Summary

Petitioner presented to Rush Copley's emergency department on June 4, 2008 (PX1 pg. 27). She provided a history of jumping out of a burning truck in February and having right arm pain ever since (PX1 pg. 27). She was diagnosed with a possible rotator cuff tear and advised to follow up with ortho (PX1 pg. 25).

Petitioner visited Dr. Steven Chudik at Hinsdale Orthopaedics on June 17, 2018 (PX8 pg. 2). Petitioner provided a history of jumping out of a burning truck and grabbing onto a rod on the outside of the truck causing her right arm to go into forced flexion and external rotation (PX8 pg. 2). She complained of immediate pain which has persisted (PX8 pg. 2). Dr. Chudik recommended an MRI and opined that Petitioner's shoulder injury was due to the work-related accident on February 8, 2008 (PX8 pg. 4).

Petitioner underwent an MRI on her right shoulder on June 21, 2008 (PX8 pg. 5). The MRI revealed a full-thickness rotator cuff tear (PX8 pg. 5). She returned to Dr. Chudik on June 23, 2008 and he recommended a right rotator cuff repair and distal clavicle resection (PX8 pg. 6).

He placed her on work restrictions of van driving with no lifting or repetitive use of the right upper extremity (PX8 pg. 6).

Petitioner returned to Rush Copley's emergency department for her right shoulder on November 3, 2008 (PX1 pg. 47). She was placed off of work until re-evaluated (PX1 pg. 49).

Petitioner presented to Dr. Paul Witt at Castle Orthopaedics on December 10, 2008 (PX2 pg. 32). She complained of shoulder pain that started in February 2008 (PX2 pg. 32). He referred her to Dr. Saleem for repair of the rotator cuff (PX2 pg. 32). She first visited Dr. Saleem on December 18, 2008 and he ordered the surgery (PX2 pg. 30-31).

Petitioner underwent surgery at Mercy Medical Center on January 12, 2009 (PX5 pg. 10-12). Dr. Saleem performed arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle excision (PX5 pg. 10). She followed up with Dr. Saleem on January 29, 2009 and was ordered to physical therapy (PX2 pg. 22).

Petitioner began physical therapy at Mercy Medical Center on February 9, 2009 (PX5 pg. 54). She completed a total of 11 visits from February 9, 2009 to April 30, 2009 (PX5 pg. 64).

Petitioner followed up with Dr. Saleem on February 19, 2009 and March 27, 2009 complaining of pain (PX2 pg. 16-19). On March 27, 2009, Petitioner complained of neck pain radiating down between her shoulder blades (PX2 pg. 16). Dr. Saleem ordered a cervical MRI (PX2 pg. 16). She returned on May 1, 2009 and had not yet had the MRI (PX2 pg. 12). On May 19, 2009, Dr. Saleem opined that her neck pain was unrelated to her rotator cuff and referred her to pain management (PX2 pg. 9-10). He also discharged her from care for her shoulder (PX2 pg. 10).

Petitioner presented to Dr. Tony Choi at MOI on April 4, 2015 (PX3 pg. 57). She was complaining of pain in her right shoulder following the surgery from 2008 (PX3 pg. 57). Dr. Choi ordered physical therapy and offered an injection, but Petitioner declined (PX3 pg. 57). Petitioner underwent physical therapy with Athletico from April 21, 2015 through July 30, 2015 for a total of 27 sessions (PX4).

Petitioner returned to Dr. Choi on April 23, 2015 and an MRI was ordered for her right shoulder (PX3 pg. 56). She had the MRI and returned to Dr. Choi on June 15, 2015 (PX3 pg. 54). At that visit, Dr. Choi noted that her MRI revealed thinning of the rotator cuff and that it is possible that the initial repair did well, but has degenerated over time (PX3 pg. 54). He also noted that she may have only had partial healing of the original repair (PX3 pg. 54). Dr. Choi discussed possible surgery and injections, but released Petitioner at that time (PX3 pg. 54).

Petitioner returned to Dr. Choi on July 11, 2017 (PX3 pg. 15). Petitioner indicate that the pain went away in 2015, but has reappeared in a similar way to the original rotator cuff tear (PX3 pg. 15). She returned to MOI on February 5, 2018 also complaining of right shoulder pain (PX3 pg. 1-3). She was diagnosed with right shoulder pain and physical therapy was ordered, but not completed (PX3 pg. 3).

Petitioner submitted the following medical expenses as a result of this treatment:

1)	Athletico	$6,274.00
2)	Provena Mercy Center	$39,351.12
3)	Rush Copley	$2,036.00
4)	Hinsdale Orthopaedics	$2,890.00
	Total	$50,551.12

Conclusions of Law

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

Respondent was operating a business covered by the Workers' Compensation Act at the time of the accident as a carrier of goods and additionally as a business using gasoline powered equipment. The arbitrator finds that Respondent was operating under and is subject to the Illinois Workers' Compensation Act.

B. Was there an employee-employer relationship?

Petitioner signed a wage agreement with Respondent and drove Respondent's truck. The truck she drove was labeled as Respondent's truck and she identified herself as a driver or Respondent. Respondent assigned the routes that Petitioner drove. The arbitrator finds that an employee-employer relationship existed between Petitioner and Respondent on the date of accident. Respondent exercised significant control over Petitioner's work and Petitioner did not hold herself out to work for anyone other than Respondent during her brief tenure.

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

Petitioner was waiting in her truck for it to be loaded when the truck started on fire. Petitioner was clearly in the course of her employment as she was in the process of making a delivery. The truck fire required Petitioner to escape from the truck as fast as possible and jump down out of danger. The risk of having to escape from a burning vehicle is one that is inherent to Petitioner's employment with Respondent. The arbitrator finds that Petitioner suffered an accident arising out of and in the course of her employment when she injured her shoulder jumping from a burning truck.

D. What was the date of the accident?

The date of the accident is February 8, 2008 as evidenced by Petitioner's testimony and corroborating medical records.

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

Petitioner testified that she provided verbal notice of the accident to Respondent. She also testified that within 45 days of the accident she also sent written notice of the accident to Respondent. As a result, the arbitrator finds that Petitioner gave timely notice of the accident to Respondent.

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

Petitioner suffered a torn rotator cuff in her right shoulder. This is the same arm she used to hold onto the safety bar as she jumped from the truck. Petitioner testified that she had no injuries to her right shoulder prior to this accident. Furthermore, Petitioner's treating physician, Dr. Chudik, opined that her condition was causally connected to the accident. The arbitrator notes the significant force applied to Petitioner's shoulder during her accident and, absent any evidence to the contrary, finds that Petitioner's right shoulder condition is causally related to her injury.

G. What were Petitioner's earnings?

Petitioner testified that she expected to earn $1,000.00 per week while working with Respondent. Petitioner stipulated that her average weekly wage was $1,000.00 per week. The arbitrator notes that in her wage agreement and pay scale with Respondent (PX9), Petitioner is set to be paid at $1.50 per mile. This is equivalent to 666.67 miles. The arbitrator notes that Petitioner traveled from Illinois to Florida and back in the one week before she was injured. This is much further than 666.67 miles.

As there was no other evidence and Petitioner stipulated to $1,000.00, the arbitrator finds that Petitioner's average weekly wage when she was injured was $1,000.00.

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

Petitioner was 52 years old at the time of the accident.

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

Petitioner was single 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?

Petitioner underwent a rotator cuff repair in January 2019 following her injury. She was also treated with physical therapy. In 2015, Petitioner sought additional treatment for her right shoulder as a follow up to the surgery. She was treated with physical therapy and was eventually released from care in 2015. The arbitrator notes that surgery and physical therapy are common, reasonable methods for treatment of Petitioner's injuries. The arbitrator finds that these medical services were reasonable and necessary.

Petitioner presented evidence of medical expenses incurred that have no been paid by Respondent. The arbitrator finds these expenses reasonable and necessary. These expenses total $50,551.12 and are subject to fee schedule reductions.

K. What temporary benefits are in dispute? TTD?

Petitioner testified that she was off of work following the injury until May 20, 2009 when she was released to full duty by Dr. Saleem following the January 12, 2009 surgery. Prior to the full duty release, she was on work restrictions that were never accommodated by Respondent. She

testified that she did not work from the time of the accident until May 20, 2019, a total of 66 3/7 weeks. The arbitrator finds that Petitioner was temporarily totally disabled for this period of time and 66 3/7 weeks of TTD benefits are due to Petitioner.

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

Petitioner suffered a full thickness rotator cuff tear that required surgery. She continued to have problems in 2015 where an MRI revealed thinning of the repaired rotator cuff. Petitioner testified that she did not have any issues with her right shoulder prior to this accident. She testified that she is more arthritic in the right shoulder following the accident. Petitioner did retire from driving in 2012.

The arbitrator finds that Petitioner is permanently partially disabled to the extent of 20% loss of use of the right arm.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC000075
Case Name	BECERRIL, FABIAN v. COMMERCIAL TIRE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0199
Number of Pages of Decision	13
Decision Issued By	Kathryn A. Doerries, Commissioner

Petitioner Attorney	Anita DeCarlo
Respondent Attorney	Christopher Tomczyk

DATE FILED: 4/26/2021

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☒ Affirm with modification as to accident date only	☐ Rate Adjustment Fund (§8(g))
COUNTY OF KANE	)	☐ 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

FABIAN BECERRIL,

Petitioner,

vs. NO: 15 WC 00075

COMMERCIAL TIRE,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, modifies the Arbitrator's Decision only as to the date of accident. Section 6(d) of the Workers' Compensation Act provides that an injured employee must file a workers' compensation claim within three years after the date of the accident. 820 ILCS 305/6(d) (West 2013). When the accident is a discrete event, the date of the accident is easy to determine: it is, obviously, the date that the employee was injured. When the accident is not a discrete event, this date is harder to specify. See *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64, 862 N.E.2d 918, 924 (2006). An employee who suffers a repetitive trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden

injury. *Durand*, 224 Ill. 2d at 64, 862 N.E.2d at 924. An employee suffering from a repetitive trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Durand*, 224 Ill. 2d at 64, 862 N.E.2d at 924. The manifestation date is a fact determination for the Commission. *Durand*, 224 Ill. 2d at 64, 862 N.E.2d at 924. The Commission's determination on a question of fact will not be disturbed on review unless it is against the manifest weight of the evidence. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 44, 509 N.E.2d 1005, 1008 (1987).

The Commission finds that Petitioner's injury became manifest on December 8, 2014, the date Petitioner sought medical treatment with Dr. Chhadia at Suburban Orthopedics where he complained of low back pain, worse on the right, and intermittent tingling in the lower extremity. The cause/mechanism was noted as "overuse work." The Commission finds this is the date the injury and its causal link to Petitioner's work became plainly apparent to a reasonable person.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified to reflect the proper date of accident as December 8, 2014. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $455.53 per week for a period of 208-2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $27,603.90 for medical expenses under §8(a) of the Act.

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

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

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

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

04/26/2021

o-3/3/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0199
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

BECERRIL, FABIAN
Employee/Petitioner

Case# **15WC000075**
15WC000191

COMMERCIAL TIRE
Employer/Respondent

On 7/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE LLC
JONEL METAJ
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60654

0445 RODDY LAW LTD
CHRIS TOMCZYK
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

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

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

Fabian Becerril
Employee/Petitioner
v.
Commercial Tire
Employer/Respondent

Case # 15 WC 075
Consolidated cases: 15 WC 191

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Geneva**, on **December 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident **December 9, 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 an accident.

In the year preceding the injury, Petitioner earned **$35,531.60;** the average weekly wage was **$683.00.**

On the date of accident, Petitioner was **34** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$18,565.94** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$18,565.94 (Which includes TTD paid for the accident of January 17, 2013, and is the subject of 15 WC 191.)**
Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay the bills totaling **$27,603.90** subject to the fee schedule and pursuant to §8 and §8.2 of the Act and subject to credit for any payments made by respondent for the claimed bills directly or through respondent's group insurance in accordance with the provisions of §8 j of the Act.

Temporary Total Benefits

Respondent shall pay **Temporary Total Disability from December 15, 2014 to December 18, 2018,** which is a total of **208-2/7 weeks** at the rate of **$455.53 per week.**

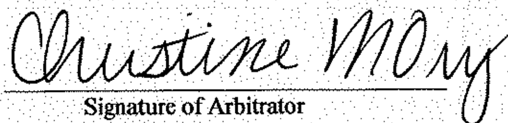
Prospective Medical benefits

Respondent shall authorize and pay for all reasonable and necessary costs of the three-level laminectomy as prescribed by Dr. McNally and all associated care, pursuant to the fee schedule and in accordance with §8 and §8.2 of the Act.

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

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

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



Signature of Arbitrator

July 24, 2019
Date

JUL 29 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fabian Becerril	)
Petitioner,	)
vs.	) **No. 15 WC 75**
Commercial Tire	)
Respondent.	)

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

This matter proceeded to hearing under the provisions of §19b/§8a in Geneva on December 11, 2018. The parties agree that on December 9, 2014, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act that their relationship was one of employee and employer. They agreed in the year predating the accident, petitioner earned $35,531.60 and his average weekly wage calculated pursuant to §10, was $683.30.

At issue in this hearing is as follows:

1. Whether petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent.
2. Whether petitioner provided timely notice within the limits of the Act.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills
5. Whether petitioner is entitled to payment for prospective medical treatment.
6. Whether petitioner is due temporary total disability.

STATEMENT OF FACTS

The Petitioner does not speak English; his native language is Spanish. He testified with the assistance of Nancy Beltran, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Beltran served as an interpreter for the petitioner.

Petitioner testified he was employed by respondent for six or seven years as of December, 2012. He is not a high school graduate. Petitioner repaired commercial tires on trucks and big machines, both inside and outside respondent's shop. The tires weighed over 100 pounds. Petitioner was required to lift the tires when doing repairs. He worked over 40 hours a week; Monday through Friday and sometimes Saturdays. He was paid $15.00 per hour.

Beginning in December, 2012, and into January, 2013, petitioner was doing his usual heavy lifting of tire when he began having pain in his back. In January, 2013, the pain was getting worse and worse. He reported to his boss, Larry Lucasek, that he was having pain in his back. Larry completed an incident report and sent petitioner to the company clinic. He went to Mercy Medical Center on January 10, 2013, where he saw Dr. Woodward. X-rays were taken. He placed on restrictions. He returned to work within the restrictions, but in pain.

He returned to Dr. Woodward a week later and physical therapy was prescribed. He continued under the care of Dr. Woodward and was released to full-duty work on February 27, 2013. He returned to Dr. Woodward on March 11, 2013. A MRI was completed on March 22, 2013. After the MRI was completed, petitioner followed up with Dr. Adarsh Patel for pain management at Rush Copley. Injections were recommended, but not obtained. Petitioner continued to work full duty.

In December, 2014, petitioner was working his full duty job. Although petitioner had seen a doctor between April, 2013 to December, 2014, he did not receive any active medical treatment. He continued to do heaving lifting of tires and his pain got worse and worse. He reported the problem to the new boss, Carlos Ruiz. Ruiz advised petitioner he completed an incident report.

Petitioner talked to the service manager, who asked him if he wanted to return to the same doctor; petitioner opted to go to his own doctor. At the recommendation of his uncle, petitioner went to Suburban Orthopedics, where he saw Dr. Ankur Chhadia in December, 2014.

Dr. Chhadia reviewed petitioner's 2013 MRI and recommended a new MRI. The new MRI was done on December 10, 2014. Petitioner returned to Dr. Chhadia, who referred petitioner to pain management doctor, Dr. Dmitry Novoseletsky. He first saw Dr. Novoseletsky on January 5, 2015, who recommended injections. Petitioner received a left S-1 transforaminal epidural steroid injection on January 14, 2105, a lumbar epidural steroid injection at L5/S1 on February 17, 2015, medial branch block at L2 through L5 on March 31, 2015, a repeat block at L2 through L5 on May 5, 2015 and a radiofrequency neurotomy at L2 through L5 on June 30, 2015. These procedures failed to alleviate his pain. He was kept off work by Dr. Novoseletsky and paid TTD benefits.

On August 17, 2015, petitioner was seen by Dr. Andrew Zelby at respondent's request. Petitioner testified that Dr. Zelby did nothing during the exam that lasted 15 minutes. After Dr. Zelby's exam, petitioner returned to Dr. Novoseletsky, who recommended more injections. Petitioner returned to Dr. Chhadia on October 23, 2015, who gave him a referral to Dr. Thomas McNally. He saw Dr. McNally on February 16, 2016. Petitioner's benefits had been stopped. His last shot had not been paid by the worker's compensation insurance. He used Blue Cross and Blue Shield to see Dr. McNally.

At the direction of Dr. McNally, petitioner obtained a MRI on February 23, 2016 and an EMG on March 29, 2016. He then returned to Dr. McNally on April 19, 2016. Dr. McNally recommended surgery. Petitioner would like to have the surgery proposed by Dr. McNally, but was not authorized. He last saw Dr. McNally on September 13, 2016.

Petitioner has not returned to work and is living with his parents.

Petitioner denied he receive any treatment to his back prior to December, 2012.

Petitioner agreed he returned to see Dr. Zelby a second time on June 17, 2016.

Medical Bills

Petitioner claims the following medical bills were incurred as a result of the two work injuries:

$2,451.00 Provena Mercy Medical Center
$20,885.00 Suburban Orthopaedics
$2,517.81 Workers' Compensation RX Solutions
$4,201.09 MedArbor

Provena Mercy Medical Center Records (PX. 2 & 3)

Petitioner was first ween by Dr. Charles Woodward on January 10, 2013 with a history of low back pain after lifting a heavy tire on December 31, 2012. The diagnosis was lumbar strain with radiculopathy. He received physical therapy. He continued under the care of Dr. Woodward until February, 2013. On February 27, 2013, Dr. Woodward reported petitioner lumbosacral strain with radiculopathy was resolving and released petitioner to return to regular work.

Petitioner returned to Dr. Woodward on March 11, 2013 and reported after he again was having back pain after testing his back by lifting heavy tires. He felt radiating pain and referred to Dr. Bhatia.

Petitioner was seen by Dr. Bhatia on March 13, 2013. Dr. Bhatia diagnosed an L5-S1 radiculopathy due to loss of left ankle jerk. A MRI was recommended. The March 22, 2013 MRI showed herniated discs.

Petitioner was seen by Dr. Adarsh Patel on April 22, 2013, who recommended injections.

Dr. Thomas McNally March 16, 2018 Deposition and Curriculum Vitae (PX.4 & 5)

Dr. Thomas McNally, board certified orthopedic surgeon, testified in behalf of petitioner. Dr. McNally first saw petitioner on February 16, 2016 as a referral by Dr. Chhadia and Dr. Novoseletsky. The history provided by petitioner was that in December of 2014 he had low back pain due to an overuse injury. Petitioner reported he was lifting tires for eight years. Petitioner reported he had received no relief from the various injections he had received. Dr. McNally found these injections were reasonable and necessary. He also believed petitioner was disabled. (7-11)

On April 19, 2016, after reviewing the new MRI and EMG that Dr. McNally had ordered, Dr. McNally recommended proceeding with laminectomies at the L3-4, L4-5 and L5-S1 levels (14-15). Dr. McNally opined that petitioner's work injury exacerbated his pre-existing conditions that became symptomatic and now required surgery. Petitioner remained disabled. Petitioner was last seen by Dr. McNally on September 13, 2016; the surgery had not yet been approved (15-17).

Dr. McNally disagreed with Dr. Zelby's conclusion that petitioner's condition was the result of the work injury (17-18). Dr. McNally pointed to the positive EMG as objective evidence to support petitioner's subjective complaints (19). Dr. McNally determined the line of work petitioner was a competent cause of petitioner's condition (19-20).

Dr. McNally recorded the negative Waddell's signs at the time of his exam on September 13, 2016 in response to Dr. Zelby's remarks (23-24). Dr. McNally did not find any symptom magnification in petitioner's case (27).

Suburban Orthopaedics Records (PX. 6)

Petitioner was first seen by Dr. Ankur Chhadia on December 8, 2014 with a history of overuse at work occurring approximately January 12, 2013. Diagnosis was multilevel lumbar herniated bulging disc with neural foraminal narrowing and encroachment. Petitioner returned to Dr. Chhadia on December 15, 2014 and referred to Dr. Novoseletsky, whom he saw on January 5, 2015.

Dr. Novoseletsky performed a left transforaminal epidural injection on January 14, 2015. Petitioner followed up with Dr. Novoseletsky on February 4, 2015. Dr. Novoseletsky performed a lumbar epidural steroid injection at L5-S1 on February 15, 2015. Petitioner followed up with Dr. Novoseletsky on March 6, 2015. Dr. Novoseletsky performed a medial branch block from L2 through L5 on March 31, 2015; petitioner followed up on April 10, 2015. Petitioner had another set of medial block injections on May 5, 2015 and June 30, 2015. Petitioner was seen in follow

up by Dr. Novoseletsky on May 22, 2015, July 20, 2015 and September 25, 2015. On September 25, 2015, Dr. Novoseletsky proposed SI joint injection. Petitioner was kept off work by Dr. Novoseletsky while under his care.

On October 23, 2015, petitioner was referred by Dr. Chhadia to Dr. Thomas McNally; and was kept off work. Petitioner was initially seen by Dr. Thomas McNally on February 16, 2016. Dr. McNally diagnosed congenital lumbar spinal stenosis, lumbosacral spondylosis with radiculopathy, lumbar degenerative disc disease and herniated disc. Dr. McNally ordered a closed MRI and a EMG. On April 19, 2016, after reviewing the February 23, 2016 MRI and March 29, 2016 EMG, Dr. McNally recommended laminectomies at L3-4, L4-5 and L5-S1 levels. Petitioner did not want to consider fusion; which was an option offered. He was kept off work by Dr. McNally during the period he was under his care.

Petitioner returned to Dr. Novoseletsky on May 20, 2016 for pain management. Injections and physical therapy was considered. Petitioner was seen by Dr. Novoseletsky on June 17, 2016, July 11, 2016, August 8, 2016 and September 12, 2016. Dr. Novoseletsky kept petitioner off work during this period as well.

Petitioner was seen again by Dr. McNally on September 13, 2016, who continued to recommend surgery and kept petitioner off work.

Dr. Andrew Zelby April 11, 2018 Deposition (RX.1)

Dr. Andrew Zelby, board certified neurosurgeon, testified in behalf of respondent. Dr. Zelby first examined petitioner on August 17, 2015. Petitioner had positive straight leg raising on his back, but negative when sitting. (The discrepancy, according to Dr. Zelby, was evidence of symptom magnification.) Sensation to pinprick in the lower left extremity was diminished. Deep tendon reflexes in the lower extremities were absent. (6-11)

Dr. Zelby diagnosis was lumbosacral spondylosis, which was degenerative. Dr. Zelby agreed petitioner had a herniated L5/S1 disc that was consistent with lumbar radiculopathy. However, Dr. Zelby noted petitioner recovered and returned to work. Dr. Zelby concluded that because petitioner's December, 2014 MRI was somewhat better than the March, 2013 MRI, the symptoms petitioner reported in December 2014 where not caused or accelerated by a claimed work accident of December, 2014. Dr. Zelby reported 4/5 positive Waddell signs. Therefore, Dr. Zelby concluded petitioner had symptom magnification. Dr. Zelby believed petitioner was at maximum medical improvement and he was able to return to work as of March or April, 2015. (12-15)

Dr. Zelby re-examined petitioner on June 17, 2016. Dr. Zelby reported the exam was normal except for vibratory sensation in the lower left extremity. The reflexes in the lower extremities were again absent. Dr. Zelby's diagnosis remained the same. Dr. Zelby believed petitioner's clinical condition did not correlate with the EMG and MRI. (15-20)

Dr. Zelby believed the treatment up to the December, 2014 claimed accident was reasonable and necessary. He did not agree that surgery was reasonable or necessary. (21-22)

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 on December 9, 2014 that arose out of and in the course of petitioner's employment by respondent, the Arbitrator finds the following facts:

Respondent does not dispute petitioner injured his back on January 17, 2013, which is the subject of 15 WC 191. Petitioner returned to work after the January 17, 2013 accident on February 27, 2013, but was in pain. Petitioner's unrefuted testimony was that he continued to work, lifting tires that weighed as much as 100 pounds, until December 8, 2014. His conditioned worsened. He was seen by Dr. Chhadia on December 8, 2014 due to overuse injury.

The Arbitrator finds, based upon the foregoing, that petitioner re-injured his back, as a result of a repetitive accident that arose out of and in the course of his employment with respondent on December 9, 2014.

D. With respect to the issue of the date of the accident, the Arbitrator finds the following facts:

The Arbitrator finds petitioner's repetitive work accident occurred on December 9, 2014, which is the date petitioner received for the overuse work injury; thus the date his condition was connected to his work activities.

E. With respect to the issue of whether petitioner gave timely notice of the claimed accident to respondent:

Petitioner, without rebuttal, testified he reported the work injury to his then-supervisor, Carlos Ruiz. Ruiz advised petitioner he would complete an incident report. According to petitioner's unrebutted testimony, the service manager offered petitioner to return to [Dr. Woodward] or seek treatment on his own.

Based upon the foregoing, the Arbitrator finds petitioner gave timely notice of the work accident of December 9, 2014.

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:

There was no evidence petitioner had prior back problems before his employment with respondent which began six or seven years before December, 2012. The unrefuted evidence was that petitioner repeatedly lifted tires that weighed 100 pounds or more that resulted into an injury to his back on January 17, 2013. Although he was released to return to work on February 27, 2013, it was not without pain. Petitioner also returned to performing his same repetitive work of lifting 100 pound tires.

Dr. McNally testified that petitioner's heavy lifting at work was a competent cause of petitioner's repetitive injury to his back. Although Dr. McNally agreed that the December 10, 2014 MRI showed there was a resorption of the left paracentral disc extrusion at L5-S1, there was still stenosis at L3-L4, L4-5 and L5-S1. Dr. McNally agreed that although petitioner had congenital spinal stenosis, the work-related injury exacerbated the condition. Petitioner's EMG of March 29, 2016 was positive for multilevel lumbosacral radiculopathy at L4, L5 and S1 levels.

Based upon the foregoing, the Arbitrator finds petitioner's current back condition, for which petitioner now requires a three-level laminectomy, was caused by the work accident of December 8, 2014.

The Arbitrator makes this finding despite the opinion of Dr. Zelby. Dr. Zelby ignored the findings on the MRIs, the positive EMG, the diminished pinprick in the lower left extremity and the absence of deep tendon reflexes in petitioner's lower extremities. He did double-speak when asked about the positive EMG. The Arbitrator agrees with Dr. McNally's assessment of Dr. Zelby's opinion that it was ridiculous for Dr. Zelby to find there was no medical basis to suggest petitioner's symptoms and lumbar condition were caused or made symptomatic as a result of the work injury or any work activities.

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

The Arbitrator finds the following bills were reasonable and necessary to treat petitioner of his work injury of December 9, 2014 and awards same pursuant to the fee schedule, §8 and §8.2 of the Act, with credit to be given for payments made directly by respondent or by the group insurance in accordance with §8 j:

$20,885.00 Suburban Orthopaedics
$2,517.81 Workers' Compensation RX Solutions
$4,201.09 MedArbor

K. With respect to the issue regarding prospective medical care, the Arbitrator makes the following conclusions of law:

Petitioner has received conservative treatment, including various injections and physical therapy, without relief. In reliance on the opinion of Dr. McNally, the Arbitrator awards the costs of surgery consisting of the three-level laminectomy, and the attendant care, to be paid in accordance with the fee schedule and §8 and §8.2 of the Act.

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

The evidence supports petitioner claimed he has been disabled from December 15, 2014 through the date of hearing of December 11, 2018, which is 208-2/7 weeks, and awards TTD for this period at the rate of $455.53 per week.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC000191
Case Name	BECERRIL, FABIAN v. COMMERCIAL TIRE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0200
Number of Pages of Decision	11
Decision Issued By	Kathryn A. Doerries, Commissioner

Petitioner Attorney	Anita DeCarlo
Respondent Attorney	Christopher Tomczyk

DATE FILED: 4/26/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FABIAN BECERRIL,

Petitioner,

vs. NO: 15 WC 00191

COMMERCIAL TIRE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 29, 2019 is hereby affirmed and adopted.

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

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 $2,600.00. 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: **04/26/2021**

o- 3/9/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

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

BECERRIL, FABIAN
Employee/Petitioner

Case# **15WC000191**

15WC000075

COMMERICAL TIRE
Employer/Respondent

On 7/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE LLC
JONEL METAJ
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0445 RODDY LAW LTD
CHRIS TOMCZYK
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

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

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

Fabian Becerril
Employee/Petitioner
v.
Commercial Tire
Employer/Respondent

Case # 15 WC 191
Consolidated cases: 15 WC 75

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Geneva**, on **December 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident **January 17, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to an accident (along with the December 9, 2014 accident.)

In the year preceding the injury, Petitioner earned **$35,531.60;** the average weekly wage was **$683.00.**

On the date of accident, Petitioner was **34** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.
Respondent ***owes*** for all reasonable and necessary medical services.
Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**

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

ORDER

Medical benefits

Respondent shall pay the bills totaling **$2,451.00** to Provena Mercy Medical Center subject to the fee schedule and pursuant to §8 and §8.2 of the Act, with to credit to be given for any payments made by respondent directly or through the group insurance in accordance with the provisions of §8 j of the Act.

Temporary Total Benefits

Respondent paid all TTD due up to the December 9, 2014 accident, which is the subject of 15 WC 75.

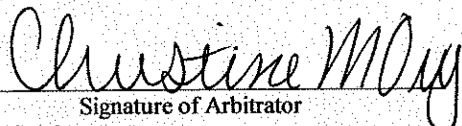
Prospective Medical benefits

Respondent shall authorize and pay for all reasonable and necessary costs of the three-level laminectomy as prescribed by Dr. McNally and all associated care, pursuant to the fee schedule and in accordance with §8 and §8.2 of the Act.

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

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

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



Signature of Arbitrator

July 24, 2019
Date

IC ArbDec19(b) p. 2

JUL 29 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fabian Becerril)
Petitioner,)
vs.) **No. 15 WC 191**
Commercial Tire)
Respondent.)

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

This matter proceeded to hearing under the provisions of §19b/§8a in Geneva on December 11, 2018. The parties agree that on January 17, 2013, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act that their relationship was one of employee and employer. They agreed in the year predating the accident, petitioner earned $35,531.60 and his average weekly wage calculated pursuant to §10, was $683.30.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills
3. Whether petitioner is entitled to payment for prospective medical treatment.

STATEMENT OF FACTS

The Petitioner does not speak English; his native language is Spanish. He testified with the assistance of Nancy Beltran, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Beltran served as an interpreter for the petitioner.

Petitioner testified he was employed by respondent for six or seven years as of December, 2012. He is not a high school graduate. Petitioner repaired commercial tires on trucks and big machines, both inside and outside respondent's shop. The tires weighed over 100 pounds. Petitioner was required to lift the tires when doing repairs. He worked over 40 hours a week; Monday through Friday and sometimes Saturdays. He was paid $15.00 per hour.

Beginning in December, 2012, and into January, 2013, petitioner was doing his usual heavy lifting of tire when he began having pain in his back. In January, 2013, the pain was getting worse and worse. He reported to his boss, Larry Lucasek, that he was having pain in his back. Larry completed an incident report and sent petitioner to the company clinic. He went to Mercy Medical Center on January 10, 2013, where he saw Dr. Woodward. X-rays were taken. He placed on restrictions. He returned to work within the restrictions, but in pain.

He returned to Dr. Woodward a week later and physical therapy was prescribed. He continued under the care of Dr. Woodward and was released to full-duty work on February 27, 2013. He returned to Dr. Woodward on March 11, 2013. A MRI was completed on March 22, 2013. After the MRI was completed, petitioner followed up with Dr. Adarsh Patel for pain

management at Rush Copley. Injections were recommended, but not obtained. Petitioner continued to work full duty.

In December, 2014, petitioner was working his full duty job. Although petitioner had seen a doctor between April, 2013 to December, 2014, he did not receive any active medical treatment. He continued to do heaving lifting of tires and his pain got worse and worse. He reported the problem to the new boss, Carlos Ruiz. Ruiz advised petitioner he completed an incident report.

Petitioner talked to the service manager, who asked him if he wanted to return to the same doctor; petitioner opted to go to his own doctor. At the recommendation of his uncle, petitioner went to Suburban Orthopedics, where he saw Dr. Ankur Chhadia in December, 2014.

Dr. Chhadia reviewed petitioner's 2013 MRI and recommended a new MRI. The new MRI was done on December 10, 2014. Petitioner returned to Dr. Chhadia, who referred petitioner to pain management doctor, Dr. Dmitry Novoseletsky. He first saw Dr. Novoseletsky on January 5, 2015, who recommended injections. Petitioner received a left S-1 transforaminal epidural steroid injection on January 14, 2105, a lumbar epidural steroid injection at L5/S1 on February 17, 2015, medial branch block at L2 through L5 on March 31, 2015, a repeat block at L2 through L5 on May 5, 2015 and a radiofrequency neurotomy at L2 through L5 on June 30, 2015. These procedures failed to alleviate his pain. He was kept off work by Dr. Novoseletsky and paid TTD benefits.

On August 17, 2015, petitioner was seen by Dr. Andrew Zelby at respondent's request. Petitioner testified that Dr. Zelby did nothing during the exam that lasted 15 minutes. After Dr. Zelby's exam, petitioner returned to Dr. Novoseletsky, who recommended more injections. Petitioner returned to Dr. Chhadia on October 23, 2015, who gave him a referral to Dr. Thomas McNally. He saw Dr. McNally on February 16, 2016. Petitioner's benefits had been stopped. His last shot had not been paid by the worker's compensation insurance. He used Blue Cross and Blue Shield to see Dr. McNally.

At the direction of Dr. McNally, petitioner obtained a MRI on February 23, 2016 and an EMG on March 29, 2016. He then returned to Dr. McNally on April 19, 2016. Dr. McNally recommended surgery. Petitioner would like to have the surgery proposed by Dr. McNally, but was not authorized. He last saw Dr. McNally on September 13, 2016.

Petitioner has not returned to work and is living with his parents.

Petitioner denied he receive any treatment to his back prior to December, 2012.

Petitioner agreed he returned to see Dr. Zelby a second time on June 17, 2016.

Medical Bills (PX.1)

Petitioner claims the following medical bills were incurred as a result of the two work injuries:

$2,451.00 Provena Mercy Medical Center
$20,885.00 Suburban Orthopaedics
$2,517.81 Workers' Compensation RX Solutions
$4,201.09 MedArbor

Provena Mercy Medical Center Records (PX. 2 & 3)

Petitioner was first ween by Dr. Charles Woodward on January 10, 2013 with a history of low back pain after lifting a heavy tire on December 31, 2012. The diagnosis was lumbar strain with radiculopathy. He received physical therapy. He continued under the care of Dr. Woodward until February, 2013. On February 27, 2013, Dr. Woodward reported petitioner lumbosacral strain with radiculopathy was resolving and released petitioner to return to regular work.

Petitioner returned to Dr. Woodward on March 11, 2013 and reported after he again was having back pain after testing his back by lifting heavy tires. He felt radiating pain and referred to Dr. Bhatia.

Petitioner was seen by Dr. Bhatia on March 13, 2013. Dr. Bhatia diagnosed an L5-S1 radiculopathy due to loss of left ankle jerk. A MRI was recommended. The March 22, 2013 MRI showed herniated discs.

Petitioner was seen by Dr. Adarsh Patel on April 22, 2013, who recommended injections.

Dr. Thomas McNally March 16, 2018 Deposition and Curriculum Vitae (PX.4 & 5)

Dr. Thomas McNally, board certified orthopedic surgeon, testified in behalf of petitioner. Dr. McNally first saw petitioner on February 16, 2016 as a referral by Dr. Chhadia and Dr. Novoseletsky. The history provided by petitioner was that in December of 2014 he had low back pain due to an overuse injury. Petitioner reported he was lifting tires for eight years. Petitioner reported he had received no relief from the various injections he had received. Dr. McNally found these injections were reasonable and necessary. He also believed petitioner was disabled. (7-11)

On April 19, 2016, after reviewing the new MRI and EMG that Dr. McNally had ordered, Dr. McNally recommended proceeding with laminectomies at the L3-4, L4-5 and L5-S1 levels (14-15). Dr. McNally opined that petitioner's work injury exacerbated his pre-existing conditions that became symptomatic and now required surgery. Petitioner remained disabled. Petitioner was last seen by Dr. McNally on September 13, 2016; the surgery had not yet been approved (15-17).

Dr. McNally disagreed with Dr. Zelby's conclusion that petitioner's condition was the result of the work injury (17-18). Dr. McNally pointed to the positive EMG as objective evidence to support petitioner's subjective complaints (19). Dr. McNally determined the line of work petitioner was a competent cause of petitioner's condition (19-20).

Dr. McNally recorded the negative Waddell's signs at the time of his exam on September 13, 2016 in response to Dr. Zelby's remarks (23-24). Dr. McNally did not find any symptom magnification in petitioner's case (27).

Suburban Orthopaedics Records (PX. 6)

Petitioner was first seen by Dr. Ankur Chhadia on December 8, 2014 with a history of overuse at work occurring approximately January 12, 2013. The diagnosis was multilevel lumbar herniated bulging disc with neural foraminal narrowing and encroachment. Petitioner returned to Dr. Chhadia on December 15, 2014 and was referred to Dr. Novoseletsky.

Dr. Novoseletsky first saw petitioner on January 5, 2015 and performed a left transforaminal epidural injection on January 14, 2015. Petitioner followed up with Dr. Novoseletsky on February 4, 2015. Dr. Novoseletsky performed a lumbar epidural steroid injection at L5-S1 on February 15, 2015. Petitioner followed up with Dr. Novoseletsky on March 6, 2015. Dr. Novoseletsky performed a medial branch block from L2 through L5 on March 31, 2015; petitioner followed up on April 10, 2015. Petitioner had another set of medial block injections on May 5, 2015 and June 30, 2015. Petitioner was seen in follow up by Dr. Novoseletsky on May 22, 2015, July 20, 2015 and September 25, 2015. On September 25, 2015, Dr. Novoseletsky proposed SI joint injection. Petitioner was kept off work by Dr. Novoseletsky while under his care.

On October 23, 2015, petitioner was referred by Dr. Chhadia to Dr. Thomas McNally; and was kept off work. Petitioner was initially seen by Dr. Thomas McNally on February 16, 2016. Dr. McNally diagnosed congenital lumbar spinal stenosis, lumbosacral spondylosis with

radiculopathy, lumbar degenerative disc disease and herniated disc. Dr. McNally ordered a closed MRI and a EMG. On April 19, 2016, after reviewing the February 23, 2016 MRI and March 29, 2016 EMG, Dr. McNally recommended laminectomies at L3-4, L4-5 and L5-S1 levels. Petitioner did not want to consider fusion; which was an option offered. He was kept off work by Dr. McNally during the period he was under his care.

Petitioner returned to Dr. Novoseletsky on May 20, 2016 for pain management. Injections and physical therapy was considered. Petitioner was seen by Dr. Novoseletsky on June 17, 2016, July 11, 2016, August 8, 2016 and September 12, 2016. Dr. Novoseletsky kept petitioner off work during this period as well.

Petitioner was seen again by Dr. McNally on September 13, 2016, who continued to recommend surgery and kept petitioner off work.

Dr. Andrew Zelby April 11, 2018 Deposition (RX.1)

Dr. Andrew Zelby, board certified neurosurgeon, testified in behalf of respondent. Dr. Zelby first examined petitioner on August 17, 2015. Petitioner had positive straight leg raising on his back, but negative when sitting. (The discrepancy, according to Dr. Zelby, was evidence of symptom magnification.) Sensation to pinprick in the lower left extremity was diminished. Deep tendon reflexes in the lower extremities were absent. (6-11)

Dr. Zelby diagnosis was lumbosacral spondylosis, which was degenerative. Dr. Zelby agreed petitioner had a herniated L5/S1 disc that was consistent with lumbar radiculopathy. However, Dr. Zelby noted petitioner recovered and returned to work. Dr. Zelby concluded that because petitioner's December, 2014 MRI was somewhat better than the March, 2013 MRI, the symptoms petitioner reported in December 2014 where not caused or accelerated by a claimed work accident of December, 2014. Dr. Zelby reported 4/5 positive Waddell signs. Therefore, Dr. Zelby concluded petitioner had symptom magnification. Dr. Zelby believed petitioner was at maximum medical improvement and he was able to return to work as of March or April, 2015. (12-15)

Dr. Zelby re-examined petitioner on June 17, 2016. Dr. Zelby reported the exam was normal except for vibratory sensation in the lower left extremity. The reflexes in the lower extremities were again absent. Dr. Zelby's diagnosis remained the same. Dr. Zelby believed petitioner's clinical condition did not correlate with the EMG and MRI. (15-20)

Dr. Zelby believed the treatment up to the December, 2014 claimed accident was reasonable and necessary. He did not agree that surgery was reasonable or necessary. (21-22)

CONCLUSIONS OF LAW

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

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

There was no evidence petitioner had prior back problems before his employment with respondent which began six or seven years before December, 2012. The unrefuted evidence was that petitioner repeatedly lifted tires that weighed 100 pounds or more that resulted into an injury to his back on January 17, 2013. Although he was released to return to work on February 27, 2013, it was not without pain. Petitioner also returned to performing his same repetitive work of lifting 100 pound tires.

Dr. McNally testified that petitioner's heavy lifting at work was a competent cause of petitioner's repetitive injury to his back. Although Dr. McNally agreed that the December 10, 2014 MRI showed there was a resorption of the left paracentral disc extrusion at L5-S1, there was still stenosis at L3-L4, L4-5 and L5-S1. Dr. McNally agreed that although petitioner had congenital spinal stenosis, the work-related injury exacerbated the condition. Petitioner's EMG of March 29, 2016 was positive for multilevel lumbosacral radiculopathy at L4, L5 and S1 levels.

Based upon the foregoing, the Arbitrator finds petitioner's current back condition, for which petitioner now requires a three-level laminectomy, was caused by the work accidents of January 17, 2013 and December 9, 2014.

The Arbitrator makes this finding despite the opinion of Dr. Zelby. Dr. Zelby ignored the findings on the MRIs, the positive EMG, the diminished pinprick in the lower left extremity and the absence of deep tendon reflexes in petitioner's lower extremities. He did double-speak when asked about the positive EMG. The Arbitrator agrees with Dr. McNally's assessment of Dr. Zelby's opinion that it was ridiculous for Dr. Zelby to find there was no medical basis to suggest petitioner's symptoms and lumbar condition were caused or made symptomatic as a result of the work injury or any work activities.

K. With respect to the issue regarding prospective medical care, the Arbitrator makes the following conclusions of law:

Petitioner has received conservative treatment, including various injections and physical therapy, without relief. In reliance on the opinion of Dr. McNally, the Arbitrator awards the costs of surgery consisting of the three-level laminectomy, and the attendant care, to be paid in accordance with the fee schedule and §8 and §8.2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC012127
Case Name	CONLEY, NADINE v. CITY OF CHICAGO DEPT. OF
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0201
Number of Pages of Decision	10
Decision Issued By	

Petitioner Attorney	Raul Rodriguez, G. Barraza
Respondent Attorney	Matthew Locke, Stephanie Lipman

DATE FILED: 4/26/2021

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

NADINE CONLEY,

Petitioner,

vs. NO: 15 WC 12127

CITY OF CHICAGO,
DEPARTMENT OF WATER MANAGEMENT,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 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: **04/26/2021**

o- 4/20/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CONLEY, NADINE
Employee/Petitioner

Case# **15WC012127**

CITY OF CHICAGO
Employer/Respondent

On 6/7/2019, 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 2.25% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
DANA KIERAS
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NADINE CONLEY
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # **15** WC **12127**

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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **December 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. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **August 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 $**71,810.83**; the average weekly wage was $**1,380.98**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**657.64** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

THE ARBITRATOR FINDS THAT, PETITIONER HAS NOT PROVEN, BEYOND A PREPONDERANCE OF THE EVIDENCE, THAT HER CONDITION OF ILL-BEING IS CAUSALLY RELATED TO HER ACCIDENT ON AUGUST 22, 2014. AS SUCH, PETITIONER'S REQUEST FOR BENEFITS UNDER THE ACT IS DENIED. ALL OTHER ISSUES ARE MOOT.

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

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

Signature of Arbitrator

06/05/19
Date

ICArbDec p. 2

JUN 7 - 2019

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on December 28, 2018 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay.

The parties proceeded to hearing with disputed issues as to whether Ms. Nadine Conley (hereinafter "Petitioner") sustained accidental injuries that arose out of and in the course of her employment with Respondent and whether Petitioner's condition of ill-being is causally connected to the injury on August 22, 2014. (Arb.X1) In addition, at issue is the nature and extent of the injury Petitioner sustained. (Arb.X1)

The parties stipulated that on August 22, 2014 Petitioner and Respondent were operating under the Illinois Workers' Compensation Act (hereinafter "Act") and had a relationship of employer and employee. (Arb.X1) The parties stipulated that the average weekly wage calculated pursuant to Section 10 of the Act was $1380.98, Petitioner was 59 years of age at the time of the injury, single, with 0 dependent children. (Arb.X1) The parties also stipulated that Petitioner did provide notice to Respondent of the accident within the time limits stated in the Act, Respondent paid $657.64 in TTD benefits to Petitioner, and all medical bills. (Arb.X1)

SUMMARY OF FACTS AND EVIDENCE

On August 22, 2014, Petitioner, Nadine Conley, was 59 years old and was employed by Respondent, the City of Chicago Department of Water Management, as an Equipment Dispatcher. Petitioner testified that she has been employed by Respondent for over thirty years.

Petitioner testified her job duties include dispatching and tracking Water Department trucks. She testified that her job duties have changed over the years given new technologies. She said that she used to do her tracking through phones and walkie talkies, but now everything is done through GPS system.

Petitioner testified on Friday, August 22, 2014, she was working in her role as a dispatcher. She was the only person on duty in her office and was trying to move her rolling chair forward, when it got stuck and as she was trying to move it while sitting, the chair broke free and caused her to hit her left knee on the file cabinet attached to her desk.

Petitioner testified that issues with the rolling chairs sticking had been a long-standing problem. She alleged that she had complained to her supervisor but was told there was no money in the budget for replacements.

Petitioner testified that following the accident, she finished her work day and then proceeded home for the weekend. Petitioner testified that she did not report the incident on that date or have her knee evaluated by a medical professional. Petitioner testified that she did not report the incident because there were no supervisors at work for her to report the incident to.

Petitioner testified that over the weekend she was walking up the stairs at her home, when her left knee gave out, causing her to fall.

Petitioner proceeded to work on Monday, August 25, 2014, and then notified her supervisor of the incident which occurred on the previous Friday. She then filled out an accident report and proceeded to MercyWorks Occupational Health (hereinafter "MercyWorks") for an evaluation by Dr. Homer Diadula (hereinafter "Dr. Diadula"). (PX1) Petitioner complained of left knee swelling with bruising and pain, 6/10 on the rating scale. (PX1) Dr. Diadula diagnosed Petitioner with a left knee contusion. He prescribed Ibuprofen, leg elevation and

an elastic knee support. (PX1)

On August 29, 2014, Petitioner was seen by Dr. Diadula for a follow-up visit. An official X-ray of her left knee was taken and there was no acute fracture of the knee. Petitioner complained of pain at a 3/10 on a rating scale in her left knee. (PX1)

Following an evaluation at MercyWorks, Petitioner was off work for approximately one week. On September 3, 2014, she then returned to work full duty. (PX1)

Petitioner continued to treat at MercyWorks and ultimately underwent an MRI. An MRI of the left knee was done on September 11, 2014 (PX3). Dr. Diadula reviewed the MRI results on September 16, 2014. The results revealed a probable small tear of the tip of the posterior horn of the lateral meniscus. (PX3) Petitioner testified that after she got the MRI, she was referred by Dr. Diadula to Chicago Center for Sports Medicine & Orthopedic Surgery (hereinafter "Chicago Orthopedic Surgery").

Petitioner began treatment with Dr. Gregory Primus (hereinafter "Dr. Primus") and Dr. Dore DeBartolo (hereinafter "Dr. DeBartolo") in October of 2014 (PX5). Petitioner's medical history information stated that she presented with a left knee contusion. (PX5) Petitioner complained of aches in her knee when she sat down or stood for a long period of time. (PX5) She underwent a course of physical therapy which she stated gave her some relief. Petitioner testified that in January 2015, she was released from care and told she was at maximum medical improvement.

Petitioner testified that she was still having pain in her knee and she went for a second opinion with Dr. Steven Gitelis (hereinafter "Dr. Gitelis") at Midwest Orthopedics at Rush in June 2015 (PX7). On June 1, 2015, Dr. Gitelis assessed that Petitioner has arthritis of both of her knees with a superimposed injury. (PX7) Dr. Gitelis told her she was a not a good candidate for knee arthroplasty/surgery. Dr. Gitelis reported that he was going to try and manage Petitioner with non-steroidals as tolerated, periodic injections, and physical therapy. (PX7) He gave Petitioner a shot in her right knee. She noted that she did not get any additional treatment following the shot.

At trial, Petitioner complained that while bending, stooping, or going up stairs her knee hurts. Petitioner testified that she now has to take showers instead of baths due to difficulty getting in and out of the tub. She also testified that she can no longer clean the gutters. However, due to the sedentary nature of her job, her left knee injury has not affected her ability to do her job.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment/Summary of Testimony:

The petitioner, Ms. Nadine Conley, was the only witness to testify at trial regarding her injury on August 22, 2014. The Arbitrator found her overall testimony to be truthful, credible and otherwise unrebutted in regard to her past medical history, course of medical treatment and current subjective complaints.

With respect to issue (C) whether an accident occurred that arose out of and in the course of employment with Respondent, 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 Petitioner proved by a preponderance of the evidence that her accident on August 22,

2014, arose out of and in the course of her employment with Respondent. "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 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury." *Brais v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 120820WC, ¶18. With respect to factual matters, it is within the province of the Commission to judge the credibility of the witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences therefrom. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill.App.3d 665, 674 (2009). In addition, there was no evidence produced at trial to the contrary. After reviewing the fact presented at trial and exhibits, the Arbitrator finds that Petitioner did sustain an injury to her left knee/leg during the course of her employment with Respondent on August 22, 2014.

Next, "in order to determine whether the Petitioner's injury arose out of her [his] employment, one must first categorize the risk to which he or she was exposed. Illinois recognizes three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App.3d 347, 352, 247 Ill. Dec. 333, 732 N.E.2d 49 (2000).

A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his or her duties. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Petitioner testified that she has worked for the City of Chicago for over 36 years in various positions. Petitioner testified that on August 22, 2014, and for the last 4 years, her position was an equipment dispatcher in an office setting. Petitioner testified that her administrative duties included breaking down the drivers call in information, send service mechanics to the drivers, notify the foremen or supervisors if their employees were going to be off, collect trip sheets from drivers and GPS track the equipment to make sure it was going to the right destination. The Arbitrator finds that in order for Petitioner to fulfill the duties of her position, she had to be in the aforementioned office setting utilizing the office equipment.

Illinois Courts have held that the existence of a defect, which the employer was aware of, can be attributed as a compensable workers' compensation injury, if that defect caused the worker to be injured. In *USF Holland v. Industrial Comm'n* 357 Ill.App.3d 798, 829 N.E.2d 810 (2005), a worker injured his foot when he tripped over a threshold in a door. Finding for the injured worker, the Court found that there was evidence that there was a small gap in the threshold, which caught the toe of the claimant's boot. In the instant case, Petitioner's unrefuted testimony was that the rolling chairs in the office had a long history of the wheels sticking. Petitioner testified that she had complained about that issue to her supervisor and the person in charge of ordering office furniture, Mr. Darrell Jackson. Petitioner testified that he responded by telling her that there was no money in the budget for additional chairs. The Arbitrator finds that the defect in Petitioner's rolling chair can be attributed to her employment and therefore her injury arose out of and was in the course of her employment with Respondent.

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. After hearing the testimony of Petitioner and reviewing the exhibits submitted, the Arbitrator finds that Petitioner's failed to prove by a preponderance of the evidence that her current condition of ill-being is causally connected to her work accident on August 22, 2014.

Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury. See *Vogel v. Industrial Commission,* 354 Ill. App. 3d 780 (2005).

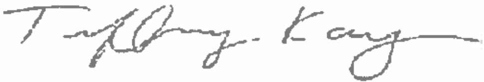
In the instant case, it is unrefuted that Petitioner finished out the rest of her day, proceeded home for the weekend and, while at home, sustained a fall. Moreover, it is also unrefuted that prior to this fall Petitioner had not reported the accident to her employer, nor had she received any medical attention. In addition, there was no testimony from Petitioner that she was in pain after her work accident or that the injury necessitated her to take any self-care medical precautions at home following the accident.

This is problematic for Petitioner's case because there is an unrefuted independent intervening accident which occurred following her alleged injury at work while Petitioner was at home the following weekend. There is no evidence demonstrating that she sought medical attention following her accident at home. Even more problematic is that Petitioner is not able to demonstrate any medical evidence opining that there was a causal connection between her prior work-related injury and her left knee through medical. There was also no witness testimony provided regarding her prior complaints regarding the chairs or her injury.

It is just as likely, that Petitioner's injuries were a direct result of falling on the stairs while at home that weekend. With no evidence to the contrary, the Arbitrator finds that Petitioner has not met her burden with respect to causation. As such, Petitioner's request for benefits under the Act is denied. All other issues are moot.

With respect to issue (L) the Nature and Extent of the injury, the Arbitrator finds as follows:

As a finding has been made that the Petitioner's current condition of ill-being is not causally related to the injury, the other disputed issues are moot.



06/05/19

Signature of Arbitrator

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	04WC013736
Case Name	RIZO, AURELIA L v. ILLINOIS STATE POLICE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0202
Number of Pages of Decision	25
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Danielle Curtiss

DATE FILED: 4/21/2021

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

Aurelia Rizo,

Petitioner,

vs. NO: 04 WC 13736

Illinois State Police – Crime Lab,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 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: **04/21/2021**
MP:yl

/s/ *Marc Parker*

o 4/15/21
68

/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

21IWCC0202

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIZO, AURELIA
Employee/Petitioner

Case# **04WC013698**

04WC013699
04WC013700
04WC013736
06WC006834
10WC039044

ILLINOIS STATE POLICE-CRIME LAB
Employer/Respondent

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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
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

JUL 31 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aurelia Rizo
Employee/Petitioner

v.

Illinois State Police – Crime Lab
Employer/Respondent

Case # **04** WC **13698**

Consolidated cases: **04 WC 13699, 04 WC 13700, 04 WC 13736, 06 WC 6834, 10 WC 39044**

An *Application for Adjustment 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 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. [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 [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent

On each of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**94,885.96**; the average weekly wage was $**1,824.73**.

On the dates of accident, Petitioner was **36, 40, 42, 43, 45, and 50** years old, respectively, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,216.49**/week for **9** weeks, commencing **June 4, 2008 through July 29, 2008, September 28, 2010 through October 2, 2010, February 8, 2013, and April 12, 2013**, as provided in Section 8(b) of the Act

Respondent shall be given a credit for all temporary total disability benefits that have been paid

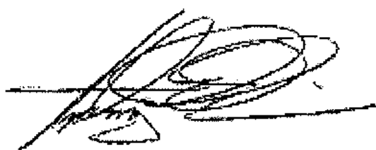
Respondent shall pay reasonable and necessary medical services of $**60,989.92**, as provided in Sections 8(a) and 8.2 of the Act

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

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **135** weeks, because the injuries sustained caused the **27%** loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

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



Arbitrator Anthony C. Erbacci

JUL 3 1 2019

July 23, 2019
Date

FACTS:

The Petitioner testified that she became employed by the Respondent as a forensic scientist on April 1, 1982 and that she continued in that employment until she retired on May 31, 2013. The Petitioner described her job duties as requiring repetitive fine motor skills and the use of a computer. Specifically, she described that she was required to cut open packages of drugs for analysis, and to input her findings into a computer. The Petitioner described that she would run tests to identify the contents of multiple items in each case, some containing up to several hundred individual pieces. These items were most often in multiple small bags or in large, wrapped packages. The Petitioner testified that she would open the items packaged in small bags using forceps and tweezers, and then sample them for testing using a spatula the thickness of a USB cord. The items packaged in large bags were often wrapped in 3-5 layers of plastic, duct tape, oil, and dryer sheets, which the Petitioner would have to cut through with an X-acto knife in order to sample and weigh the materials inside.

The Petitioner testified that she would weigh all specimens individually, take samples and place them into small glass vials the size of a fingernail, or pipette the samples using a dropper bottle. The vials the specimens were placed into needed to be crimped and uncrimped with a squeezing motion so they could be tested. The Petitioner testified that she also frequently used pliers, scissors, pens, scalpels, and X-acto knives with her right hand. The Petitioner testified that her work also involved squeezing a manual scanner to sign in evidence and carrying boxes of evidence from the evidence storage area to her workstation.

The Petitioner claims to have been injured six times during the course of her employment with the Respondent: first on January 9, 1996, then on February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Claim Number 04 WC 13698

The Petitioner testified that on January 9, 1996, she was working on a multi-item drug case that required her to open tiny bags with forceps and tweezers, sample each item with a spatula, and follow the protocol required for each case: weigh the sample, take a sample of one set using a dropper bottle for a color test, take another sample, dilute it, and place it into an instrument using a capper, and then type the information into the computer and repackage and mark every single item. The Petitioner testified that by the time she was done with this particular case, her right hand had turned purple and cold to the touch, and she had pain in her right forearm all the way up to her right shoulder and neck. The Petitioner testified that her arm was in such pain that she had difficulty pushing a door open to leave the room. The Petitioner testified that she told her direct supervisor, Sally Dillon, about the incident and her pain.

A "Supervisor's Report of Injury or Illness" was eventually completed by Sally Dillon on May 2, 1996. In this report, it is noted that on January 11, 1996 the Petitioner reported an injury on January 9, 1996 when she experienced intense pain in her right wrist area, thumb, palm and forearm while taking samples of evidence.

The Petitioner testified that she continued to work following that incident and then sought treatment from Dr. Richard Brannegan for her right shoulder, arm and hand pain. A March 27, 1996 letter report from Dr. Brannegan, addressed to Dr. John Olivieri at Meyer Medical, was admitted into

the record as Petitioner's Exhibit 4. The Arbitrator notes that no records of treatment from Dr. Olivieri were offered into evidence. In his report, Dr. Brannegan noted that the Petitioner likely had an overuse syndrome with pain in the right hand and wrist coming from local sources such as the tendons and soft tissues of the forearm. Dr. Brannegan also noted that Petitioner's work demanded a fair amount of repetitive fine hand movement which aggravated the problem. He recommended some anti-inflammatory medications, splinting of the hand, and physical therapy.

On July 9, 1996, it was noted that the Petitioner then attended 13 sessions of physical therapy for thoracic outlet syndrome at HealthSouth, which were apparently prescribed by Dr. Olivieri. On July 8, 1997, the Petitioner underwent a Functional Capacity Evaluation at Health South which indicated that Petitioner could work in the medium demand level and perform all activities of her job.

Claim Number 04 WC 13699

The Petitioner testified that on February 8, 2000, she was injured for a second time when working several multiple-item drug cases on the same day. The Petitioner testified that, for each item in each case, she would follow the same steps to test, inventory, repackage, and mark the exhibit. She testified that by the end of the day, her right hand was purple and tingling with severe pain through her wrist and arm. A "Notice of Injury" form was completed on February 22, 2000 wherein the Petitioner reported an injury to her right hand, right wrist, neck, right shoulder, and right forearm. Timely notice of this injury is not disputed.

Following the February 8, 2000 injury, the Petitioner sought treatment with Dr. William Baylis at Parkview Musculoskeletal Institute on February 29, 2000. Petitioner complained of four to five years of right-hand medial elbow pain radiating to her right side of her neck, and also noted the poor ergonomic environment of her job and her job duties. Dr. Baylis prescribed a custom forearm splint and an EMG test which was performed on March 8, 2000 and reported to be normal study. On March 16, 2000, Dr. Baylis ordered an ergonomically correct workstation for Petitioner and limited her repetitive motion to four hours out of an eight-hour workday.

The Petitioner then sought treatment with a chiropractor, Kurt James Keppner, D.C. Dr. Keppner's impression was that the Petitioner sustained a repetitive motion injury to the cervico-thoracic spine, and he recommended chiropractic care.

On November 20, 2000, the Petitioner was examined by Dr. Michael Bednar at the request of the Respondent. Dr. Bednar's impression was that Petitioner likely had a variant of thoracic outlet syndrome. He agreed with Dr. Baylis' plan for improving Petitioner's ergonomic work situation. He opined that additional physical therapy and chiropractic manipulation would not improve her condition and that she would not benefit from surgery. Dr. Bednar indicated that the Petitioner was not at a level of maximal medical improvement, and he recommended that she get an ergonomically improved workstation and continue with Dr. Baylis' restrictions of limiting repetitive work to only 50 percent of Petitioner's workday.

On April 24, 2001 Dr. Bednar noted that some ergonomic changes had been made to the Petitioner's workstation which she felt had improved some of her symptoms. On June 1, 2001Dr. Bednar noted that an MRI of the Petitioner's cervical spine had been completed and demonstrated

som mild stenosis at C6-7. Dr. Bednar then referred the Petitioner to Dr. Alexander Ghanayem at Loyola.

On June 27, 2001, the Petitioner saw Dr. Ghanayem who indicated that her MRI findings were incidental and did not correlate with her symptoms. Dr. Ghanayem did not believe that the Petitioner had a cervical spine etiology for her right upper extremity symptoms.

Claim Number 04 WC 13700

The Petitioner testified that on July 3, 2001, she was injured for a third time. The Petitioner testified that, for some time, she had been breaking up her day to avoid repetitive tasks but, on this date, she was working on a case where 14,055 grams of plant material were wrapped in layers of saran wrap, duct tape, and dryer sheets. The Petitioner testified that she cut the package open with a scalpel and X-acto knife, sampled it, and repackaged it. She testified that while repackaging the item, she experienced extreme pain in her right hand, wrist, fingers, arm, shoulder, neck and elbow.

A "Notice of Injury" form was eventually completed in which the Petitioner described an injury to her right hand which felt numb, cold, and tingly. She also reported that her right arm and right wrist area hurt the entire day and evening, and her right hand, right wrist, neck and right shoulder ached for several days. Timely notice of this injury is not disputed.

Following the July 3, 2001 injury, the Petitioner returned to Dr. Bednar at Loyola on August 14, 2001. Dr. Bednar noted that the Petitioner's symptoms were now more significant for numbness and tingling in the median nerve distribution. Dr. Bednar placed Petitioner on a 20 lbs. work restriction and discussed a future EMG test. Petitioner was also sent for biofeedback and occupational therapy which was performed at Rehabilitation Institute of Chicago. The Respondent accommodated the Petitioner's physical restrictions.

On November 13, 2001, Petitioner returned to Dr. Bednar, who noted no point tenderness, and that Petitioner could return to work without restrictions. However, Dr. Bednar also told Petitioner to change her tasks over the day and not be as repetitive. Dr. Bednar placed Petitioner at maximum medical improvement on this date.

The Petitioner then saw Dr. John Shea, a neurosurgeon at Loyola, from March to May of 2002. Dr. Shea noted right sided neck pain radiating to the right arm and hand and tingling into the right hand. Dr. Shea reviewed Petitioner's cervical MRI and did not see evidence of thoracic outlet syndrome. He allowed Petitioner to continue to work with the restrictions of Dr. Bednar.

On June 18, 2002, Dr. Bednar saw Petitioner again and his current diagnosis was pain of the neck and arms which are of undefined etiology. Dr. Bednar referred Petitioner to Dr. William Sullivan at Loyola in the physical medicine and rehabilitation department, to see if there was any further treatment available for Petitioner. Petitioner was allowed to return to work full duty without restriction on June 19, 2002. Dr. Bednar did note that the Petitioner's symptoms increased during the workday and aggravated her current condition, and that it was difficult to determine when she would reach maximum medical improvement.

On July 17, 2002, the Petitioner saw Dr. Sullivan who noted a diagnosis of chronic pain likely of myofascial origin in the shoulder and scapular regions. Dr. Sullivan showed Petitioner exercises, prescribed medications, and stated she was at maximum medical improvement. Dr. Sullivan recommended Petitioner take breaks throughout the workday.

Claim Number 04 WC 13736

The Petitioner testified that on November 25, 2003, she was injured for a fourth time. The Petitioner testified that over several days, she worked on a drug case that contained 57 small item baggies. The Petitioner testified that for each item, she was required to open the bag, weigh the specimen, mark it, write down the weight, complete preliminary testing on the color of the specimen using a dropper bottle, take another sample with the spatula, clean it off, mark the vial, add a solvent, use a pipette to decant the liquid into another vial, then crimp or screw the cap on a vial and mark it. The Petitioner testified that she needed to take frequent breaks and do her prescribed stretching throughout the project. She testified that she completed the case successfully, but experienced excruciating pain from holding the scalpels, pens, scissors, and other small and thin tools. She testified that the pain was tingling and radiated from her right thumb and wrist up to her elbow, right shoulder, and right neck. She reported the injury to her supervisor.

An "Employer's First Report of Injury" form was eventually completed and indicated a work accident of November 25, 2003 from repetitive motion while Petitioner was opening 57 bags of specimens for analysis. The report mentioned right shoulder and neck pain.

On February 6, 2004, the Petitioner sought treatment with Dr. Charles Carroll. Dr. Carroll noted a history of Petitioner's significant workload that involved multiple bags of data, wherein she developed pain in the shoulder, elbow, and hand. She complained of pain in the right neck, right chest, subclavicular region anterior shoulder, and along the course of the ulnar nerve. Dr. Carroll noted numbness and tingling in the right hand consistent with carpal tunnel syndrome. Dr. Carroll noted that there was evidence of right thoracic outlet syndrome and mild evidence of left thoracic outlet syndrome. Her neurological exam also showed evidence of ulnar neuritis and carpal tunnel syndrome. Dr. Carroll also noted possible shoulder instability. He recommended physical therapy and an MRI. He also allowed Petitioner to continue working but to not do heavy lifting and to vary her job tasks.

The Petitioner participated in physical therapy and occupational therapy at Northwestern Center for Orthopedics. She also underwent an MRI of the right shoulder on February 12, 2004 at High Tech Medical Park which was a normal study.

On February 23, 2004, Petitioner returned to Dr. Carroll who reviewed prior medical records and diagnostic studies. Dr. Carroll noted several positive physical and neurological examination findings and indicated that Petitioner had evidence of neuritis at the ulnar nerve and carpal tunnel region, even in the face of normal electrodiagnostic studies. She also had evidence of possible cervical radiculitis. Dr. Carroll recommended continued physical therapy, and an MRI of the cervical spine. He allowed Petitioner to continue working but instructed her to vary her job duties. Dr. Carroll considered Petitioner's present condition of ill-being to be aggravated by the work that she does.

Petitioner continued therapy, but with OccuSport physical therapy, throughout March and April 2004. On March 20, 2004, the Petitioner underwent a cervical MRI at High Tech Medical Park.

On May 5, 2004, Dr. Carroll noted a diagnosis of cervical spondylosis based on the March 20, 2004 MRI. Dr. Carroll recommended that Petitioner see Dr. Srdjan Mirkovic for the cervical condition and indicated that he has not yet determined that the cervical spine is the sole cause of her arm pain. Dr. Carroll noted that the Petitioner was not at maximum medical improvement but could continue working exercising care with highly repetitive activities.

Petitioner saw Dr. Mirkovic at Northwestern on June 16, 2004. Dr. Mirkovic noted complaints of neck and right arm pain radiating to the elbow and occasionally the hand with right shoulder pain. Dr. Mirkovic opined that the Petitioner's current symptoms were an aggravation of a pre-existing cervical spondylosis and he recommended a CT myelogram of the cervical spine.

The CT Myelogram was performed on August 2, 2004. Dr. Mirkovic reviewed the CT myelogram on August 17, 2004 and noted foraminal stenosis on the right at C4-5 greater than C5-6. Dr. Mirkovic noted that some of Petitioner's symptoms may be emanating from nerve root compression secondary to the foraminal stenosis. He discussed possible surgical options and recommended right C5 and C6 nerve root blocks.

On October 20, 2004, Dr. Jeff Katz performed the cervical epidural steroid injection to Petitioner's right C5-6. He noted that Petitioner's neck and shoulder felt 50 percent better after the injection. Her thumb pain was unchanged. She did not have any pain in the medial forearm, but also didn't have much pain in the forearm prior to the injection on this date. Dr. Katz noted that Petitioner could continue regular work duties but must wear an elbow pad for ulnar neuritis.

On November 9, 2004, Dr. Mirkovic noted Petitioner's benefit from cervical injection and recommended another injection. He diagnosed foraminal stenosis with radiculopathy.

Claim Number 06 WC 6834

The Petitioner testified that on November 3, 2005, she sustained a fifth injury. She testified that she had been working on a case that contained 51 items in paper bags. She had to perform the same series of steps on these items as with all the other cases, which resulted in severe pain in her right hand, right thumb, right wrist, right elbow, right shoulder, and neck. She told her supervisor on that date that she needed medical treatment. Timely notice of this injury is not disputed.

On February 17, 2006, the Petitioner returned to Dr. Carroll and complained of pain in the right elbow. Dr. Carroll diagnosed right lateral epicondylitis, cervical radiculitis, and sprains and strains of the right wrist and right hand. He ordered a new thumb Spica splint and allowed Petitioner to continue full duty work. Dr. Carroll considered the conditions work-related. Petitioner began physical therapy at OccuSport which she performed for six weeks.

The Petitioner returned to Dr. Carroll on April 14, 2006 and he noted Petitioner complained of chronic pain in the right elbow and some discomfort in the right lateral epicondyle. She also still had neck and right shoulder complaints. Dr. Carroll diagnosed triceps tendonitis and lateral epicondylitis.

Dr. Carroll referred Petitioner to Dr. Mirkovic and kept her at full duty. Petitioner continued physical therapy.

The Petitioner returned to Dr. Carroll on June 12, 2006 and he noted that her neurologic examination confirmed some epicondylitis and ulnar neuritis. Dr. Carroll recommended the Petitioner continue working, consider seeing a physiatrist, and follow up with a spine surgeon.

On August 1, 2006, Petitioner saw Dr. Mirkovic, who noted neck pain, right scapular and shoulder pain, and right arm ache. He prescribed an MRI of the cervical spine, and an EMG/NCV study of the upper extremity.

Petitioner underwent a cervical spine MRI on August 4, 2006 which showed multilevel degenerative changes. An EMG/NCV study performed on August 4, 2006 was reported to be an abnormal study indicative of chronic, mild, right C5-7 cervical polyradiculopathy without evidence of ongoing denervation. There was no electrodiagnostic evidence of a right medial mononeuropathy at the wrist or ulnar mononeuropathy.

Petitioner sought treatment with Dr. Brian Couri of the Chicago Institute of Neurosurgery and Neuroresearch on August 14, 2006. Dr. Couri's assessment included; 1) right-sided snapping scapula secondary to scapular stabilizing muscle weakness which is very prominent with significant scapular dysfunction; 2) right medial and lateral epicondylitis most likely due to overuse from the scapular dysfunction; 3) positive Hawkins' sign on the right side with right-sided impingement syndrome which is probably secondary to the scapular dysfunction with rotator cuff overuse and the weakness of the rotator cuff muscles; 4) bilateral neck pain over bilateral C2-3, C3-4, and C4-5 cervical zygapophyseal joints with left-sided osteoarthritis and right C1-2 zygapophyseal joint dysfunction, probably more secondary to the muscle imbalances but could very well be due to discomediated pain causing some pain in the cervical spine and leading to the capsular dysfunction; 5) Right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis which very well could be causing the patient to have the cervical spine pain and the shoulder pain leading to the scapular dysfunction which is the main cause of all of the rest of the patient's current symptoms; 6) Right-sided thoracic outlet syndrome, more prominent than that on the left side, which is more than likely functional in nature as opposed to any true impingement upon the thoracic outlet. It is probably more functional due to the scapular stabilizing weakness. Dr. Couri prescribed physical therapy and allowed Petitioner to continue full duty work.

Petitioner continued physical therapy at OccuSport and followed up with Dr. Couri. On October 9, 2006, Dr. Couri's assessment was a right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis; 2) right-sided functional thoracic outlet syndrome; 3) what appears to be a right very mild C5 radiculitis/radiculopathy; 4) right scapular dysfunction with shoulder impingement secondary to the C5 radiculopathy. Dr. Couri recommended a right C5 transforaminal epidural steroid injection, which was performed on October 31, 2006.

On November 7, 2006, the Petitioner was involved in an unrelated motor vehicle accident. The Petitioner testified that she was hit while making a U-turn and suffered *left* upper trapezius muscle pain and *left-sided* neck pain, neither of which exacerbated the right-sided neck pain she was experiencing from her work injury. The Petitioner testified that there was no injury to her right upper extremity in this automobile accident.

On November 13, 2006, Petitioner attended physical therapy with OccuSport and the therapist noted that Petitioner's recent motor vehicle accident affected the left upper trapezius and had no effect on the work-related right side. It was noted that the Petitioner reported an overall improvement in her right-sided symptoms since her epidural injection on October 31, 2006. On November 14, 2006 Dr. Couri noted that the motor vehicle accident caused left scapular/shoulder-area spasms and increased left sided neck pain, but that her right-sided neck pain did not become any worse. He allowed Petitioner to continue working full duty.

Dr. Couri performed additional injections to the right C2-3, C5-6, and C6-7 zygapophyseal joints on December 19, 2006. Petitioner continued therapy.

On February 2, 2007, Petitioner saw Dr. Couri again and he recommended that Petitioner continue full time work but to do one-third less cases, and to instead spend that time doing something like teaching which she had done in the past. Dr. Couri ordered another EMG/NCV test of the right arm and an elbow injection.

An MRI arthrogram of the Petitioner's right shoulder was performed on June 14, 2007 at Future Diagnostics Group and was reported to be unremarkable.

The Petitioner was then referred by Dr. Couri to Dr. Giridhar Burra at Hinsdale Orthopedic Associates on June 22, 2017. Dr. Burra noted several positive physical exam findings relative to the right shoulder. Dr. Burra reviewed diagnostics and made a diagnosis of biceps tendinitis and a possible superior labrum anterior and posterior lesion. Dr. Burra recommended a diagnostic right shoulder arthroscopy.

On July 16, 2007, Petitioner returned to Dr. Couri who agreed with Dr. Burra's plan of diagnostic right shoulder arthroscopy. Dr. Couri stated that "it appears all of her symptoms came about with chronic repetitive work and lifting of heavy objects, and I believe that her right shoulder is the main cause of her symptoms which has exacerbated the neck and now the elbow." Dr. Couri placed Petitioner on 10 lbs. lifting restrictions and no overhead work.

On August 1, 2007, Petitioner was involved in another unrelated motor vehicle accident. She was taken to Silver Cross Hospital and complained of a left upper arm abrasion, a right shoulder abrasion, and mid lower back pain. The Petitioner testified that she only experienced slight soreness on her left side as a result of this accident.

On September 21, 2007, Dr. Burra authored a letter indicating that Petitioner's right shoulder/bicep symptoms preceded the motor vehicle accident and that she never had relief of symptoms prior to the motor vehicle accident. Accordingly, Dr. Burra opined that her shoulder symptoms were primarily related to her work injury and did not believe that the motor vehicle accident caused the injury.

On June 4, 2008, the Petitioner underwent right shoulder surgery at Silver Cross Hospital with Dr. Burra. The post-operative diagnosis was a SLAP lesion, subacromial bursitis and mild impingement in the right shoulder. The procedure consisted of right shoulder arthroscopy, SLAP lesion repair and subacromial decompression. Following surgery, Petitioner continued following up with Dr. Burra and performing physical therapy.

On November 19, 2008, the Petitioner reported to Dr. Burra that her right shoulder was doing well with increasing motion. However, she had a complaint on this date of rather extreme exacerbation of left elbow epicondylitis. She was diagnosed with left lateral epicondylitis. Dr. Burra recommended therapy for both the right shoulder and left elbow, and to remain restricted at work.

On January 7, 2009, Dr. Burra noted that Petitioner had made great progress with the right shoulder and could discontinue therapy and progress to a home exercise program. Dr. Burra placed Petitioner on restrictions for the right shoulder of no lifting greater than 25 lbs. and recheck in 6 weeks. Relative to the left elbow, Petitioner still complained of left elbow pain, worse with any gripping or lifting. Dr. Burra recommended a cortisone injection and continuation of physical therapy. The injection was done on this date. Dr. Burra also placed restrictions of no gripping with the left arm.

On April 17, 2009, Dr. Burra noted that Petitioner was pretty much asymptomatic for the right shoulder. He placed Petitioner at maximum medical improvement for her right shoulder and allowed her to return to full duty without restriction. However, for her continued right elbow symptoms, Dr. Burra noted that Petitioner had previous complaints suggestive of ulnar neuritis. He also noted that people with shoulder surgeries are at a higher risk because of the significant amount of flexion with performance of the rehab and immobilization after shoulder surgery, and this would put this condition for an exacerbation. He diagnosed ulnar nerve neuropathy and recommended a night splint. For the left elbow, Dr. Burra performed another injection and discussed possible surgical intervention if not improved. She was returned back to work with restrictions of no gripping with the left hand.

On June 25, 2009, the Petitioner saw Dr. Burra and reported that she was symptomatic in regard to her right elbow, complaining of paresthesia to the right ulnar nerve distribution. She was also tender over the left lateral epicondyle in the left elbow. Dr. Burra stated that "her right shoulder pathology [was] related causally to her right elbow symptoms..." For the left elbow lateral epicondylitis, he stated it is not a traumatic condition but an overuse syndrome. Dr. Burra discussed surgical options and recommended an MRI of the left elbow. A left elbow MRI was performed on July 9, 2009 at Future Diagnostics Group.

Dr. Burra reviewed the MRI of the left elbow on July 29, 2009 and diagnosed left epicondylitis. However, Petitioner reported improvement in her symptoms, and wanted to defer any surgical intervention unless symptoms worsen. Dr. Burra allowed her to continue to work with limitations of no repetitive gripping in the left hand, and to follow-up as needed.

On August 1, 2009, the Petitioner returned to Dr. Mirkovic for neck and right shoulder pain, and he ordered an MRI of the cervical spine and an EMG/NCV of the right upper extremity.

The Petitioner returned to Dr. Burra on December 2, 2009 complaining of increased right shoulder pain that freezes, cracks and pops, as well as increased pain with overhead activities or reaching behind or across her body. Dr. Burra diagnosed right elbow lateral epicondylitis as well as cubital tunnel syndrome. He recommended a repeat MRI arthrogram, and also to return after the EMG was done relative to the right elbow.

The Petitioner returned to Dr. Burra on January 6, 2010. Despite a negative EMG, Dr. Burra felt that the Petitioner had left elbow cubital tunnel syndrome and recommended ulnar nerve transposition surgery. For the right elbow, he diagnosed lateral epicondylitis, and recommended conservative treatment. Relative to the right shoulder, the MRI arthrogram showed some post-

surgical changes, but Dr. Burra recommended trying to manage it conservatively. The Petitioner was kept on restrictions of no repetitive gripping and no lifting greater than 5 lbs.

On July 2, 2010, the Petitioner had another EMG with Dr. Wayne Kelly of Health Benefits Pain Management. The EMG was noted to be abnormal, and the impression was 1) a right-sided chronic underlying chronic C6-7 cervical radiculopathy with evidence of primarily chronic axonal involvement; 2) a superimposed right-sided mild chronic compression/entrapment ulnar neuropathy across the elbow (Cubital tunnel syndrome) with evidence of mild focal demyelination and mild chronic axonal involvement, likely indicative of a double crush injury; 3) a bilateral moderate chronic compression/entrapment median mono neuropathies at the wrist (carpal tunnel syndrome) with evidence of moderate focal demyelination of both sensory and motor nerves as well as chronic axonal involvement; 4) no electrophysiological evidence of an underlying sensory/motor polyneuropathy or right brachial plexopathy. Dr. Kelly recommended two C6-7 cervical injections, a right ulnar nerve steroid block along the ulnar nerve, and a right distal medial nerve steroid block at the carpal tunnel and use of cock-up wrist splints.

Claim Number 10 WC 39044

The Petitioner testified that on August 2, 2010, she was injured for a sixth time when working on a case with several kilos of plant material wrapped in multiple layers of saran wrap. The Petitioner testified that she was using an X-acto knife to cut open the packages and enter the information into the computer. By the time she was done analyzing, sampling, and repackaging, her right and left hands, wrists, and thumbs were in significant pain.

The Petitioner reported the incident to her supervisor and an accident report was eventually completed. The Petitioner reported in the accident report that she was opening packaged kilos of cannabis. She had to cut open the package and remove the cannabis for weight and analysis. During these job duties, she felt pain in her right wrist, right elbow, left wrist, and bilateral hands. Timely notice of this injury is not disputed.

On August 16, 2010, the Petitioner returned to Dr. Burra, and she reported that her right shoulder pain was significantly resolved, and her left elbow pain was improved. She complained, however, that she was very limited and affected by her right elbow pain. She reported the recent work activity of opening multiple kilo packs which involved significant flexion/extension across her right elbow and had worsened her symptoms. Dr. Burra reviewed the EMG from July 2010. Dr. Burra indicated that Petitioner had a double crush condition. Dr. Burra recommended ulnar nerve transposition surgery.

Surgery was performed on September 28, 2010 to the right elbow. The pre-and-post operative diagnosis was ulnar nerve compression neuropathy of the right elbow. The procedure performed consisted of right-side ulnar nerve anterior transposition with a subcutaneous technique. Petitioner was placed on sedentary work/paperwork only duties.

Petitioner continued following-up with Dr. Couri in 2010 and did physical therapy for the post-operative right elbow.

On November 17, 2010, Dr. Burra recorded that Petitioner's numbness and tingling in her right 4th and 5th fingers was resolving post-surgery. Her left elbow was asymptomatic as of this date. Dr. Burra placed Petitioner on continued work restrictions.

On December 28, 2010, Dr. Burra noted that the Petitioner's right 4th and 5th finger symptoms had resolved. Her right elbow was doing much better. Noting that the Petitioner's right elbow, right shoulder, and left elbow symptoms were under control, Dr. Burra released her from his care. Dr. Bura indicated that the Petitioner was able to return to work relative to the right elbow, right shoulder and left elbow, but he noted that the Petitioner was still treating with Dr. Couri for carpal tunnel syndrome.

The Petitioner continued treatment with Dr. Couri in early 2011 for bilateral carpal tunnel syndrome. On January 10, 2011, she complained of bilateral hand symptoms which were improving. She still had a complaint of left elbow pain at this visit and she reported that her work aggravated both conditions. Dr. Couri kept Petitioner on work restrictions.

On March 25, 2011, Dr. Couri performed a left eblow lateral epicondyle injection, and instructed Petitioner to continue using a cock-up wrist splint. She was kept on work restrictions. On April 19, 2011, Dr. Couri recommended another cervical MRI, and kept Petitioner on work restrictions.

On May 23, 2011, Dr. Couri reviewed the April 26, 2011 MRI. Petitioner reported doing better with the left elbow pain since the injection. She was still having mild left lateral elbow pain and left sided neck pain. Dr. Couri recommended left C6 and C7 transforaminal epidural steroid injections and physical therapy, which Petitioner wanted to defer for the time being. She would instead try a home traction unit for one to two weeks first. She was kept on work restrictions. Dr. Couri performed an additional left elbow injection on August 2, 2011.

The Petitioner continued following up with Dr. Couri in 2012. By October 1, 2012, Dr. Couri noted that Petitioner had bilateral wrist pain and weakness. She reported numbness and tingling with fine motor activities, and also decreased grip. Dr. Couri's diagnoses was bilateral moderate carpal tunnel syndrome. He discussed bilateral percutaneous carpal tunnel release surgery in the future. She was kept on work restrictions.

On October 26, 2012, Petitioner underwent bilateral *percutaneous* carpal tunnel release surgeries with Dr. Couri.

She returned to Dr. Couri on December 6, 2012 who noted that the carpal tunnel releases had failed. He referred the Petitioner to Dr. John Fernandez at Midwest Orthopedics at Rush for another opinion.

The Petitioner saw Dr. Fernandez for the first time on January 9, 2013, and he diagnosed the Petitioner with bilateral carpal tunnel syndrome, bilateral thumb CMC joint osteoarthritis, and bilateral upper extremity pain. He recommended bilateral carpal tunnel release procedures.

On February 8, 2013, Petitioner underwent left wrist carpal tunnel release with Dr. John Fernandez. On February 25, 2013, Dr. Fernandez noted that Petitioner's paresthesias in the left hand had nearly completely resolved.

On April 12, 2013, Petitioner underwent right wrist carpal tunnel release surgery with Dr. Fernandez. Petitioner saw Dr. Fernandez on April 29, 2013, who noted improvement after right wrist surgery relative to numbness and tingling. Her main complaint on this day was pillar pain primarily worse on the right than left, worse with direct pressure of the palm and also worse with lifting activities. Dr. Fernandez noted that Petitioner could work with restrictions until June 1, 2013 at which time she would be at maximum medical improvement and able to return to full duty work.

The Petitioner testified that she lost one day of work for each carpal tunnel surgery and that the Respondent continued to accommodate her restrictions. She testified that she did less repetitive work and she participated in more teaching activities at work.

The Petitioner continued to work on restricted duty until May 31, 2013 when she voluntarily retired from her employment with the State of Illinois.

On May 27, 2015, the Petitioner returned to Dr. Fernandez with complaints of a bump/nodule on her left palm which was slightly tender to palpation and bothered her when performing gripping and working out activities. Relative to the right upper extremity, she complained of volar wrist pain. Her neurologic complaints from the median nerve distribution were completely resolved at this point. Dr. Fernandez performed a physical exam which noted a slight thickening of the surgical site along the left palm, and also a Dupuytren's nodule associated with the middle finger of the left palm. Relative to the right wrist, she had very minimal swelling along the volar aspect. She had full range of motion of the hand, wrist, and elbow. X-rays were performed which revealed ulnar positive variance by approximately 2mm. Dr. Fernandez' diagnoses were 1) left hand Dupuytren's disease, nodular phase; 2) bilateral upper extremity pain beginning while working as a chemist in 2012. Some medications were prescribed, and she was told to follow-up as needed.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

The Petitioner was examined at the request of her attorney by Dr. Samuel Chmell on October 15, 2015. Dr. Chmell's deposition testimony was admitted into the record as Petitioner's Exhibit 20. Dr. Chmell testified as to his understanding of the Petitioner's job duties and work history as well as her history of injuries and his examination findings. Dr. Chmell made the following seven diagnoses for the Petitioner: 1) bilateral carpal tunnel syndrome and multiple tendinitis, both wrists status post bilateral carpal tunnel releases times two; 2) right elbow cubital tunnel syndrome, status post ulnar nerve decompression and anterior transposition; 3) right shoulder SLAP lesion and impingement

syndrome, status post arthroscopy SLAP repair and subacromial decompression; 4) right shoulder snapping scapula syndrome; 5) bilateral elbow lateral and medial epicondylitis; 6) traumatic aggravation of degenerative disc disease in cervical spine with right upper extremity radiculopathy; and 7) right thoracic outlet syndrome.

Relative to causation, Dr. Chmell testified as to each of his seven diagnoses:

Relative to the bilateral carpal tunnel syndrome/multiple tendonitis hands and wrist, status post bilateral carpal tunnel release times two, Dr. Chmell testified that these conditions are causally related to Petitioner's work accidents of January 9, 1996, February 8, 2000, July 3, 2001, and August 2, 2010. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right cubital tunnel syndrome, status post ulnar nerve decompression and anterior decompression and interior transposition, Dr. Chmell testified that this condition was causally related to the July 3, 2001 and the August 2, 2010 work accidents. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right shoulder SLAP lesion and impingement syndrome status post arthroscopy, SLAP repair and subacromial decompression, Dr. Chmell testified that this condition was causally related to the work accident of November 25, 2003, which was aggravated on November 3, 2005. Dr. Chmell testified that this injury was a result of Petitioner's repetitive activities at work and that all treatment for those conditions to date has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right shoulder snapping scapular syndrome, Dr. Chmell testified that this condition is causally related to the November 25, 2003 work accident which was later aggravated during the November 3, 2005 work accident. Dr. Chmell testified that all treatment for this condition was reasonable, necessary, and causally related to the work accidents.

Relative to the diagnosis of bilateral elbow lateral and medial epicondylitis, Dr. Chmell testified that the right arm condition was causally related to the July 3, 2001 work accident and was further aggravated by the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell testified that the left elbow condition became involved after the August 2, 2010 work accident. Dr. Chmell opined that all treatment to date for these conditions has been reasonable, necessary, and related to the work accidents.

Relative to the diagnosis of cervical spinal traumatic aggravation of degenerative disc disease with right upper extremity radiculopathy, Dr. Chmell testified that this condition was causally related to the work accident of February 8, 2000, and further aggravated by the July 3, 2001, November 3, 2005, and August 2, 2010 work accidents. The condition was confirmed by positive EMG findings following the November 3, 2005 work accident. Dr. Chmell opined that all treatment to date for this condition has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right thoracic outlet syndrome, Dr. Chmell testified that this condition was causally related to the February 8, 2000 work accident, which was later aggravated during the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell opined that all

treatment for this condition to date has been reasonable, necessary, and related to the work accidents.

Dr. Chmell reviewed several accident reports which were included in Petitioner's Deposition Exhibit #4 at the deposition and noted that Petitioner's job duties as described in the reports are consistent with the type of activity that could cause the conditions he diagnosed.

Dr. Chmell opined that as of the date he saw Petitioner on October 15, 2015, Petitioner was at maximum medical improvement. Dr. Chmell also opined that Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma. Finally, Dr. Chmell testified that Petitioner's work restrictions in this case have been related to her work injuries.

Dr. Chmell testified that he disagreed with Dr. Verma's conclusion that the Petitioner's work was not consistent with a mechanism to cause A-C joint arthrosis or biceps tendon superior labral tearing. Dr. Chmell opined that repetitive motion activities can affect the shoulder when the labrum is stressed and eventually shreds and tears. Dr. Chmell further disagreed with Dr. Verma's conclusion that Petitioner reached MMI on March 17, 2008. Dr. Chmell disagreed because he believed Petitioner's shoulder surgery on June 4, 2008 helped her condition.

At the request of the Respondent, the Petitioner was examined by Dr. Nikhil Verma on March 17, 2008 and April 17, 2017 and he performed a record review on January 10, 2018. Dr. Verma's April 4, 2018 deposition testimony was admitted into the record as Respondent's Exhibit 20.

With regard to his examination of the Petitioner on March 17, 2008, Dr. Verma testified that he examined the Petitioner and reviewed the Petitioner's medical records from 2002 through 2007. Dr. Verma testified that he didn't review a written description of the Petitioner's job duties in preparation for the exam but the Petitioner described to him that her work as a forensic scientist involved using her hands for fine work, including opening small packages and testing substances and powders. Dr. Verma's diagnosis was right upper extremity pain with possible cervical spondylosis and radiculopathy. Dr. Verma did not believe this to be causally related to her job duties, because he did not locate a diagnosis within the shoulder that would be responsible for her symptoms, which he viewed to be diffuse in nature and not explained by the Petitioner's AC joint, biceps, or SLAP problems. Dr. Verma further testified that a repetitive use type mechanism is not consistent with a SLAP pathology in an individual of the Petitioner's age group.

Dr. Verma stated that degenerative changes in the labrum are common for patients in Petitioner's age group, and that the only repetitive use mechanism that generates SLAP tears is throwing a baseball at 80-plus miles per hour, which is not an activity in which he believed Petitioner was participating. Dr. Verma stated that repetitive work would be similarly inconsistent with superior labral pathology. Dr. Verma did not believe that the Petitioner's clinical exam findings supported the diagnosis of superior labral pathology, given their diffuse nature involving multiple components of her upper extremity.

Dr. Verma opined that Petitioner did not require any additional medical treatment for her shoulder related to a work injury, did not require any work restrictions, and was at maximum medical improvement.

With regard to his examination of the Petitioner on March 17, 2017, Dr. Verma testified that he reviewed the Petitioner's medical records from Dr. Burra, pain management records, records from Hinsdale Orthopedics, and records from Dr. Chmell. Dr. Verma noted that Petitioner's bilateral shoulders were normal aside from healed incisions on the right side and he indicated that the Petitioner demonstrated full range of motion, normal cervical motion, normal neurovascular systems, and no provocative testing findings on either shoulder. Dr. Verma opined that the Petitioner's right shoulder was essentially normal both objectively and subjectively. She had undergone right shoulder SLAP repair, which Dr. Verma did not believe was causally related to the work activities. Dr. Verma also opined that Petitioner was at maximum medical improvement for the shoulders, that no additional treatment was needed, and that she did not require any work restrictions relative to the shoulders.

With regard to his review of additional medical records of the Petitioner's treatment from 1996 through 2010, Dr. Verma testified that he also reviewed a job description in conjunction with authoring this report. Following his review of the updated records, Dr. Verma diagnosed the Petitioner with chronic upper extremity pain with possible fibromyalgia-type symptoms. Dr. Verma again stated that he did not believe Petitioner's condition to be causally related to her job duties.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

After reviewing all testimony and evidence, the Arbitrator hereby finds that the Petitioner did sustain accidents that arose out of and in the course of her employment by the Respondent on January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010. The accidents are supported by the Petitioner's testimony and corroborated by the accident reports and the treating medical records.

The respondent did not call any witnesses to dispute the Petitioner's version of her job duties or how the accidents occurred.

With regard to the issue of Notice, the Arbitrator notes that the Respondent only disputed the issue of timely notice with regard to the initial injury of January 9, 1996 (Claim Number 04 WC 13698). Based upon the Petitioner's unrebutted testimony, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Several of Petitioner's treating physicians provided opinions as to causation in this case over the years.

On March 27, 1996, while referring to Petitioner's soft tissue/tendons in the right forearm, Dr. Brannegan noted that "it sounds as if [Petitioner's] work demands a fair amount of repetitive fine hand movement, and this probably aggravates this problem."

Dr. Bayliss indicated in February and March of 2000 that Petitioner's symptoms are related to the ergonomics of her workstation and recommended altering the workstation.

Kurt James Keppner, D.C. noted on April 28, 2000 that Petitioner's condition has deteriorated over the last four months caused by her overuse at an ergonomically unsound workstation that places undue stress and strain on her neck and upper back.

On May 30, 2002, Dr. Shea at Loyola noted that "working aggravates all of her symptoms" while discussing Petitioner's neck, right arm, right thumb and grip strength.

On June 18, 2002, Dr. Bednar noted "I believe the work that she does aggravates her current condition." He also ordered her workstation be modified.

On February 6, 2004, Dr. Charles Carroll at Northwestern noted "[Petitioner] has an ongoing problem which has been further aggravated by her more recent work stress" while discussing a possible diagnosis of neuritis of the upper extremity. On February 26, 2004, Dr. Carroll stated, "I have considered her present condition of ill-being to be aggravated by the work that she discussed in previous correspondence."

Dr. Burra at Hinsdale Orthopedics stated on August 16, 2001 that "while the shoulder per se does not cause her ulnar nerve symptoms at the elbow... I have seen incidence or worsening of cubital tunnel syndrome following shoulder surgery because of the degree and duration of flexion that is required across the elbow both in the immediate postoperative period while she is in the sling as well as during the course of rehabilitative exercise and physical therapy following shoulder surgery, and I have seen this in my practice where there is an aggravation of this. As such, there is some relationship between her shoulder surgery and her elbow symptoms."

Dr. Burra also opined as to causation for the right shoulder SLAP lesion and biceps tendinitis in his September 21, 2007 correspondence. In this note, Dr. Burra opined that there is a clear-cut causal relationship of the work injury of November 3, 2005 to the right shoulder condition. He ruled out the auto accident as a cause of her condition.

Dr. Samuel Chmell, who examined the Petitioner at her attorney's request, testified that the sum of all the Petitioner's job duties involved repetitive stressful and difficult movements of Petitioner's upper extremities, right greater than left. He testified that the Petitioner did these tasks for 32 years, which was significant because her job duties subjected her upper extremities to repetitive motion activities, which is akin to overuse activities. Dr. Chmell testified that the Petitioner's job duties are consistent with the type of activity that could cause the conditions diagnosed in this case.

Dr. Chmell found seven diagnoses, which he opined were causally related to one or more of the work accidents in this case. Dr. Chmell noted that the Petitioner did not have any problems with her neck or upper extremities prior to working as a forensic chemist for the Respondent. Dr. Chmell

opined that the following seven diagnosed conditions were causally related to the Petitioner's work accidents:

1) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Nikhil Verma, the Respondent's examining physician, opined that Petitioner's diagnosis was chronic upper extremity pain with possible fibromyalgia-type symptoms. He did not feel that these conditions were causally related to her job duties. Dr. Verma only evaluated Petitioner relative to her bilateral shoulders and he did not evaluate her for any other body parts or conditions.

After reviewing all of the medical records, testimony and evidence, the Arbitrator finds the causation opinions of Petitioner's treating doctors to be consistent with the evidence and persuasive. The opinions and testimony of Dr. Samuel Chmell are credible and well-founded. Dr. Chmell's opinions correlate with those of Petitioner's treating doctors. Dr. Chmell also understood Petitioner's job duties consistent with Petitioner's testimony. While the Arbitrator notes the findings and opinions of Dr. Verma, the Arbitrator finds the causation opinions of the Petitioner's treating physicians, including Drs. Brannnegan, Carroll, Bayliss, Keppner, Shea, and Bednar to be persuasive. The Arbitrator also finds the opinions of Dr. Sam Chmell to be sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's work injuries on January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

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:

At trial, Petitioner submitted evidence of unpaid medical bills totaling $58,148.92, as summarized in Petitioner's Exhibit 31. Dr. Chmell testified that all medical treatment rendered to the Petitioner for her diagnosed conditions was reasonable, necessary, and causally related to the work accidents in this case. The Arbitrator hereby adopts the opinions of Dr. Chmell, which are sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof and finds that the unpaid medical bills totaling $58,148.92 set forth in Petitioner's Exhibit 31 are reasonable, necessary, and causally related to the work accidents of January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Additionally, the Petitioner submitted evidence of out-of-pocket travel/mileage costs as summarized in Petitioner's Exhibit 31. Section 8(a) of the Act states that the employer shall pay for treatment, vocational rehabilitation, and all services reasonably required to cure or relieve the effects

of the accidental injury. 820 ILCS 305(8)(a). Travel expenses are awarded in cases where it was reasonably necessary for the petitioner to travel in order to receive medical treatment. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). Here, the Petitioner's travel for treatment from 1996 through 2012 was for physical therapy, doctor's appointments, and testing, which all constitute reasonable travel expenses under the law. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate.

The Petitioner's mileage for travel to and from medical appointments as submitted in Petitioner's Exhibit 31 totals 17,629 miles. Applying the appropriate "IRS medical" rate applicable at the time of the travel, results in the total amount of $2,841.00 due. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate in the amount of $2,841.00.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she underwent surgery to her right shoulder on June 4, 2008 and that she was off work as a result of that surgery through July 29, 2008, a period of 8 weeks. The Petitioner testified that she underwent surgery to her right elbow on September 28, 2010 and that she was off work as a result of that surgery through October 2, 2010, a period of 5/7 weeks. The Petitioner underwent surgery to her left and right hands on February 8, 2013 and April 12, 2013, respectively, and that she was off work for one day after each of those surgeries, a period of 2/7 weeks. Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits for the periods of June 4, 2008 through July 29, 2008, a period of 8 weeks, September 28, 2010 through October 2, 2010, a period of 5/7 weeks, February 8, 2013, a period of 1/7 weeks, and April 12, 2013, a period of 1/7 weeks.

While the Petitioner claimed to be entitled to Temporary Partial Disability benefits for the hours of work that she missed obtaining treatment and therapy, the Arbitrator finds that the Petitioner failed to provide sufficient specific evidence of the actual periods of disability to allow the calculation of the exact amount of Temporary Partial Disability benefits that may be due, if any. The Arbitrator finds, therefore, that the Petitioner failed to meet its burden of proof with regard to what Temporary Partial Disability benefits, if any, are due. Accordingly, no Temporary Partial Disability benefits are awarded herein.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that Dr. Fernandez, the last physician who treated the Petitioner, noted that the Petitioner would be at maximum medical improvement by June 1, 2013 at which time she would be able to return to full duty work.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into

the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

Dr. Chmell, who examined the Petitioner at the request of her attorney on October 15, 2015, found seven diagnoses, which he opined were causally related to one or more of the Petitioner's work accidents:

2) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Chmell opined that the Petitioner was at maximum medical improvement. Dr. Chmell also opined that the Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a cumulative result of the Petitioner's six work injuries the Petitioner sustained permanent partial disability to her whole person to the extent of 27% thereof.

In Support of the Arbitrator's Decision relating to (N.), Is Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent claimed a credit under Section 8(j) of $17,894.58 (04WC13699); $3,955.04 (04WC13736); $33,044.57 (06WC6834). Respondent entered exhibits #13, 14, and 15 in support of their alleged 8(j) credit. Petitioner disputed the Respondent's entitlement to an 8(j) credit at the time of arbitration.

However, after the hearing on June 4, 2019, the parties entered into a stipulation on June 5, 2019 wherein they agreed that "the payments made by the Respondent referred to and contained in Respondent's exhibits 13, 14, and 15 were made by the workers' compensation claims department who administers, pays, and adjusts workers' compensation claims for the State of Illinois. The State

of Illinois is a self-insured employer under the Illinois Workers' Compensation Act. They are not payments made by a group insurance carrier."

The Arbitrator finds that the Respondent is entitled to credit for all of the 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC006834
Case Name	RIZO, AURELIA v. STATE OF ILLINOIS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0203
Number of Pages of Decision	25
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Danielle Curtiss

DATE FILED: 4/21/2021

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

Aurelia Rizo,

Petitioner,

vs. NO: 06 WC 6834

Illinois State Police – Crime Lab,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 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: **4/21/2021**

/s/ *Marc Parker*

MP:yl
o 4/15/21
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/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0203

NOTICE OF ARBITRATOR DECISION

RIZO, AURELIA
Employee/Petitioner

Case# **04WC013698**

04WC013699
04WC013700
04WC013736
06WC006834
10WC039044

ILLINOIS STATE POLICE-CRIME LAB
Employer/Respondent

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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
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

JUL 31 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aurelia Rizo
Employee/Petitioner

v.

Illinois State Police – Crime Lab
Employer/Respondent

Case # **04** WC **13698**

Consolidated cases: **04 WC 13699, 04 WC 13700, 04 WC 13736, 06 WC 6834, 10 WC 39044**

An *Application for Adjustment 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 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. [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 [ ] Maintenance [x] TTD

L. [x] What is the nature and extent of the injury?

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

N. [x] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On **January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On each of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**94,885.96**; the average weekly wage was $**1,824.73**.

On the dates of accident, Petitioner was **36, 40, 42, 43, 45, and 50** years old, respectively, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,216.49**/week for **9** weeks, commencing **June 4, 2008 through July 29, 2008, September 28, 2010 through October 2, 2010, February 8, 2013, and April 12, 2013**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for all temporary total disability benefits that have been paid.

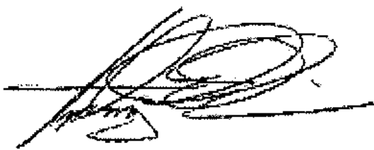
Respondent shall pay reasonable and necessary medical services of $**60,989.92**, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **135** weeks, because the injuries sustained caused the **27%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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



Arbitrator Anthony C. Erbacci

JUL 31 2019

July 23, 2019
Date

FACTS:

The Petitioner testified that she became employed by the Respondent as a forensic scientist on April 1, 1982 and that she continued in that employment until she retired on May 31, 2013. The Petitioner described her job duties as requiring repetitive fine motor skills and the use of a computer. Specifically, she described that she was required to cut open packages of drugs for analysis, and to input her findings into a computer. The Petitioner described that she would run tests to identify the contents of multiple items in each case, some containing up to several hundred individual pieces. These items were most often in multiple small bags or in large, wrapped packages. The Petitioner testified that she would open the items packaged in small bags using forceps and tweezers, and then sample them for testing using a spatula the thickness of a USB cord. The items packaged in large bags were often wrapped in 3-5 layers of plastic, duct tape, oil, and dryer sheets, which the Petitioner would have to cut through with an X-acto knife in order to sample and weigh the materials inside.

The Petitioner testified that she would weigh all specimens individually, take samples and place them into small glass vials the size of a fingernail, or pipette the samples using a dropper bottle. The vials the specimens were placed into needed to be crimped and uncrimped with a squeezing motion so they could be tested. The Petitioner testified that she also frequently used pliers, scissors, pens, scalpels, and X-acto knives with her right hand. The Petitioner testified that her work also involved squeezing a manual scanner to sign in evidence and carrying boxes of evidence from the evidence storage area to her workstation.

The Petitioner claims to have been injured six times during the course of her employment with the Respondent: first on January 9, 1996, then on February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Claim Number 04 WC 13698

The Petitioner testified that on January 9, 1996, she was working on a multi-item drug case that required her to open tiny bags with forceps and tweezers, sample each item with a spatula, and follow the protocol required for each case: weigh the sample, take a sample of one set using a dropper bottle for a color test, take another sample, dilute it, and place it into an instrument using a capper, and then type the information into the computer and repackage and mark every single item. The Petitioner testified that by the time she was done with this particular case, her right hand had turned purple and cold to the touch, and she had pain in her right forearm all the way up to her right shoulder and neck. The Petitioner testified that her arm was in such pain that she had difficulty pushing a door open to leave the room. The Petitioner testified that she told her direct supervisor, Sally Dillon, about the incident and her pain.

A "Supervisor's Report of Injury or Illness" was eventually completed by Sally Dillon on May 2, 1996. In this report, it is noted that on January 11, 1996 the Petitioner reported an injury on January 9, 1996 when she experienced intense pain in her right wrist area, thumb, palm and forearm while taking samples of evidence.

The Petitioner testified that she continued to work following that incident and then sought treatment from Dr. Richard Brannegan for her right shoulder, arm and hand pain. A March 27, 1996 letter report from Dr. Brannegan, addressed to Dr. John Olivieri at Meyer Medical, was admitted into

the record as Petitioner's Exhibit 4. The Arbitrator notes that no records of treatment from Dr. Olivieri were offered into evidence. In his report, Dr. Brannegan noted that the Petitioner likely had an overuse syndrome with pain in the right hand and wrist coming from local sources such as the tendons and soft tissues of the forearm. Dr. Brannegan also noted that Petitioner's work demanded a fair amount of repetitive fine hand movement which aggravated the problem. He recommended some anti-inflammatory medications, splinting of the hand, and physical therapy.

On July 9, 1996, it was noted that the Petitioner then attended 13 sessions of physical therapy for thoracic outlet syndrome at HealthSouth, which were apparently prescribed by Dr. Olivieri. On July 8, 1997, the Petitioner underwent a Functional Capacity Evaluation at Health South which indicated that Petitioner could work in the medium demand level and perform all activities of her job.

Claim Number 04 WC 13699

The Petitioner testified that on February 8, 2000, she was injured for a second time when working several multiple-item drug cases on the same day. The Petitioner testified that, for each item in each case, she would follow the same steps to test, inventory, repackage, and mark the exhibit. She testified that by the end of the day, her right hand was purple and tingling with severe pain through her wrist and arm. A "Notice of Injury" form was completed on February 22, 2000 wherein the Petitioner reported an injury to her right hand, right wrist, neck, right shoulder, and right forearm. Timely notice of this injury is not disputed.

Following the February 8, 2000 injury, the Petitioner sought treatment with Dr. William Baylis at Parkview Musculoskeletal Institute on February 29, 2000. Petitioner complained of four to five years of right-hand medial elbow pain radiating to her right side of her neck, and also noted the poor ergonomic environment of her job and her job duties. Dr. Baylis prescribed a custom forearm splint and an EMG test which was performed on March 8, 2000 and reported to be normal study. On March 16, 2000, Dr. Baylis ordered an ergonomically correct workstation for Petitioner and limited her repetitive motion to four hours out of an eight-hour workday.

The Petitioner then sought treatment with a chiropractor, Kurt James Keppner, D.C. Dr. Keppner's impression was that the Petitioner sustained a repetitive motion injury to the cervico-thoracic spine, and he recommended chiropractic care.

On November 20, 2000, the Petitioner was examined by Dr. Michael Bednar at the request of the Respondent. Dr. Bednar's impression was that Petitioner likely had a variant of thoracic outlet syndrome. He agreed with Dr. Baylis' plan for improving Petitioner's ergonomic work situation. He opined that additional physical therapy and chiropractic manipulation would not improve her condition and that she would not benefit from surgery. Dr. Bednar indicated that the Petitioner was not at a level of maximal medical improvement, and he recommended that she get an ergonomically improved workstation and continue with Dr. Baylis' restrictions of limiting repetitive work to only 50 percent of Petitioner's workday.

On April 24, 2001 Dr. Bednar noted that some ergonomic changes had been made to the Petitioner's workstation which she felt had improved some of her symptoms. On June 1, 2001Dr. Bednar noted that an MRI of the Petitioner's cervical spine had been completed and demonstrated

som mild stenosis at C6-7. Dr. Bednar then referred the Petitioner to Dr. Alexander Ghanayem at Loyola.

On June 27, 2001, the Petitioner saw Dr. Ghanayem who indicated that her MRI findings were incidental and did not correlate with her symptoms. Dr. Ghanayem did not believe that the Petitioner had a cervical spine etiology for her right upper extremity symptoms.

Claim Number 04 WC 13700

The Petitioner testified that on July 3, 2001, she was injured for a third time. The Petitioner testified that, for some time, she had been breaking up her day to avoid repetitive tasks but, on this date, she was working on a case where 14,055 grams of plant material were wrapped in layers of saran wrap, duct tape, and dryer sheets. The Petitioner testified that she cut the package open with a scalpel and X-acto knife, sampled it, and repackaged it. She testified that while repackaging the item, she experienced extreme pain in her right hand, wrist, fingers, arm, shoulder, neck and elbow.

A "Notice of Injury" form was eventually completed in which the Petitioner described an injury to her right hand which felt numb, cold, and tingly. She also reported that her right arm and right wrist area hurt the entire day and evening, and her right hand, right wrist, neck and right shoulder ached for several days. Timely notice of this injury is not disputed.

Following the July 3, 2001 injury, the Petitioner returned to Dr. Bednar at Loyola on August 14, 2001. Dr. Bednar noted that the Petitioner's symptoms were now more significant for numbness and tingling in the median nerve distribution. Dr. Bednar placed Petitioner on a 20 lbs. work restriction and discussed a future EMG test. Petitioner was also sent for biofeedback and occupational therapy which was performed at Rehabilitation Institute of Chicago. The Respondent accommodated the Petitioner's physical restrictions.

On November 13, 2001, Petitioner returned to Dr. Bednar, who noted no point tenderness, and that Petitioner could return to work without restrictions. However, Dr. Bednar also told Petitioner to change her tasks over the day and not be as repetitive. Dr. Bednar placed Petitioner at maximum medical improvement on this date.

The Petitioner then saw Dr. John Shea, a neurosurgeon at Loyola, from March to May of 2002. Dr. Shea noted right sided neck pain radiating to the right arm and hand and tingling into the right hand. Dr. Shea reviewed Petitioner's cervical MRI and did not see evidence of thoracic outlet syndrome. He allowed Petitioner to continue to work with the restrictions of Dr. Bednar.

On June 18, 2002, Dr. Bednar saw Petitioner again and his current diagnosis was pain of the neck and arms which are of undefined etiology. Dr. Bednar referred Petitioner to Dr. William Sullivan at Loyola in the physical medicine and rehabilitation department, to see if there was any further treatment available for Petitioner. Petitioner was allowed to return to work full duty without restriction on June 19, 2002. Dr. Bednar did note that the Petitioner's symptoms increased during the workday and aggravated her current condition, and that it was difficult to determine when she would reach maximum medical improvement.

On July 17, 2002, the Petitioner saw Dr. Sullivan who noted a diagnosis of chronic pain likely of myofascial origin in the shoulder and scapular regions. Dr. Sullivan showed Petitioner exercises, prescribed medications, and stated she was at maximum medical improvement. Dr. Sullivan recommended Petitioner take breaks throughout the workday.

Claim Number 04 WC 13736

The Petitioner testified that on November 25, 2003, she was injured for a fourth time. The Petitioner testified that over several days, she worked on a drug case that contained 57 small item baggies. The Petitioner testified that for each item, she was required to open the bag, weigh the specimen, mark it, write down the weight, complete preliminary testing on the color of the specimen using a dropper bottle, take another sample with the spatula, clean it off, mark the vial, add a solvent, use a pipette to decant the liquid into another vial, then crimp or screw the cap on a vial and mark it. The Petitioner testified that she needed to take frequent breaks and do her prescribed stretching throughout the project. She testified that she completed the case successfully, but experienced excruciating pain from holding the scalpels, pens, scissors, and other small and thin tools. She testified that the pain was tingling and radiated from her right thumb and wrist up to her elbow, right shoulder, and right neck. She reported the injury to her supervisor.

An "Employer's First Report of Injury" form was eventually completed and indicated a work accident of November 25, 2003 from repetitive motion while Petitioner was opening 57 bags of specimens for analysis. The report mentioned right shoulder and neck pain.

On February 6, 2004, the Petitioner sought treatment with Dr. Charles Carroll. Dr. Carroll noted a history of Petitioner's significant workload that involved multiple bags of data, wherein she developed pain in the shoulder, elbow, and hand. She complained of pain in the right neck, right chest, subclavicular region anterior shoulder, and along the course of the ulnar nerve. Dr. Carroll noted numbness and tingling in the right hand consistent with carpal tunnel syndrome. Dr. Carroll noted that there was evidence of right thoracic outlet syndrome and mild evidence of left thoracic outlet syndrome. Her neurological exam also showed evidence of ulnar neuritis and carpal tunnel syndrome. Dr. Carroll also noted possible shoulder instability. He recommended physical therapy and an MRI. He also allowed Petitioner to continue working but to not do heavy lifting and to vary her job tasks.

The Petitioner participated in physical therapy and occupational therapy at Northwestern Center for Orthopedics. She also underwent an MRI of the right shoulder on February 12, 2004 at High Tech Medical Park which was a normal study.

On February 23, 2004, Petitioner returned to Dr. Carroll who reviewed prior medical records and diagnostic studies. Dr. Carroll noted several positive physical and neurological examination findings and indicated that Petitioner had evidence of neuritis at the ulnar nerve and carpal tunnel region, even in the face of normal electrodiagnostic studies. She also had evidence of possible cervical radiculitis. Dr. Carroll recommended continued physical therapy, and an MRI of the cervical spine. He allowed Petitioner to continue working but instructed her to vary her job duties. Dr. Carroll considered Petitioner's present condition of ill-being to be aggravated by the work that she does.

Petitioner continued therapy, but with OccuSport physical therapy, throughout March and April 2004. On March 20, 2004, the Petitioner underwent a cervical MRI at High Tech Medical Park.

On May 5, 2004, Dr. Carroll noted a diagnosis of cervical spondylosis based on the March 20, 2004 MRI. Dr. Carroll recommended that Petitioner see Dr. Srdjan Mirkovic for the cervical condition and indicated that he has not yet determined that the cervical spine is the sole cause of her arm pain. Dr. Carroll noted that the Petitioner was not at maximum medical improvement but could continue working exercising care with highly repetitive activities.

Petitioner saw Dr. Mirkovic at Northwestern on June 16, 2004. Dr. Mirkovic noted complaints of neck and right arm pain radiating to the elbow and occasionally the hand with right shoulder pain. Dr. Mirkovic opined that the Petitioner's current symptoms were an aggravation of a pre-existing cervical spondylosis and he recommended a CT myelogram of the cervical spine.

The CT Myelogram was performed on August 2, 2004. Dr. Mirkovic reviewed the CT myelogram on August 17, 2004 and noted foraminal stenosis on the right at C4-5 greater than C5-6. Dr. Mirkovic noted that some of Petitioner's symptoms may be emanating from nerve root compression secondary to the foraminal stenosis. He discussed possible surgical options and recommended right C5 and C6 nerve root blocks.

On October 20, 2004, Dr. Jeff Katz performed the cervical epidural steroid injection to Petitioner's right C5-6. He noted that Petitioner's neck and shoulder felt 50 percent better after the injection. Her thumb pain was unchanged. She did not have any pain in the medial forearm, but also didn't have much pain in the forearm prior to the injection on this date. Dr. Katz noted that Petitioner could continue regular work duties but must wear an elbow pad for ulnar neuritis.

On November 9, 2004, Dr. Mirkovic noted Petitioner's benefit from cervical injection and recommended another injection. He diagnosed foraminal stenosis with radiculopathy.

Claim Number 06 WC 6834

The Petitioner testified that on November 3, 2005, she sustained a fifth injury. She testified that she had been working on a case that contained 51 items in paper bags. She had to perform the same series of steps on these items as with all the other cases, which resulted in severe pain in her right hand, right thumb, right wrist, right elbow, right shoulder, and neck. She told her supervisor on that date that she needed medical treatment. Timely notice of this injury is not disputed.

On February 17, 2006, the Petitioner returned to Dr. Carroll and complained of pain in the right elbow. Dr. Carroll diagnosed right lateral epicondylitis, cervical radiculitis, and sprains and strains of the right wrist and right hand. He ordered a new thumb Spica splint and allowed Petitioner to continue full duty work. Dr. Carroll considered the conditions work-related. Petitioner began physical therapy at OccuSport which she performed for six weeks.

The Petitioner returned to Dr. Carroll on April 14, 2006 and he noted Petitioner complained of chronic pain in the right elbow and some discomfort in the right lateral epicondyle. She also still had neck and right shoulder complaints. Dr. Carroll diagnosed triceps tendonitis and lateral epicondylitis.

Dr. Carroll referred Petitioner to Dr. Mirkovic and kept her at full duty. Petitioner continued physical therapy.

The Petitioner returned to Dr. Carroll on June 12, 2006 and he noted that her neurologic examination confirmed some epicondylitis and ulnar neuritis. Dr. Carroll recommended the Petitioner continue working, consider seeing a physiatrist, and follow up with a spine surgeon.

On August 1, 2006, Petitioner saw Dr. Mirkovic, who noted neck pain, right scapular and shoulder pain, and right arm ache. He prescribed an MRI of the cervical spine, and an EMG/NCV study of the upper extremity.

Petitioner underwent a cervical spine MRI on August 4, 2006 which showed multilevel degenerative changes. An EMG/NCV study performed on August 4, 2006 was reported to be an abnormal study indicative of chronic, mild, right C5-7 cervical polyradiculopathy without evidence of ongoing denervation. There was no electrodiagnostic evidence of a right medial mononeuropathy at the wrist or ulnar mononeuropathy.

Petitioner sought treatment with Dr. Brian Couri of the Chicago Institute of Neurosurgery and Neuroresearch on August 14, 2006. Dr. Couri's assessment included; 1) right-sided snapping scapula secondary to scapular stabilizing muscle weakness which is very prominent with significant scapular dysfunction; 2) right medial and lateral epicondylitis most likely due to overuse from the scapular dysfunction; 3) positive Hawkins' sign on the right side with right-sided impingement syndrome which is probably secondary to the scapular dysfunction with rotator cuff overuse and the weakness of the rotator cuff muscles; 4) bilateral neck pain over bilateral C2-3, C3-4, and C4-5 cervical zygapophyseal joints with left-sided osteoarthritis and right C1-2 zygapophyseal joint dysfunction, probably more secondary to the muscle imbalances but could very well be due to discomediated pain causing some pain in the cervical spine and leading to the capsular dysfunction; 5) Right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis which very well could be causing the patient to have the cervical spine pain and the shoulder pain leading to the scapular dysfunction which is the main cause of all of the rest of the patient's current symptoms; 6) Right-sided thoracic outlet syndrome, more prominent than that on the left side, which is more than likely functional in nature as opposed to any true impingement upon the thoracic outlet. It is probably more functional due to the scapular stabilizing weakness. Dr. Couri prescribed physical therapy and allowed Petitioner to continue full duty work.

Petitioner continued physical therapy at OccuSport and followed up with Dr. Couri. On October 9, 2006, Dr. Couri's assessment was a right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis; 2) right-sided functional thoracic outlet syndrome; 3) what appears to be a right very mild C5 radiculitis/radiculopathy; 4) right scapular dysfunction with shoulder impingement secondary to the C5 radiculopathy. Dr. Couri recommended a right C5 transforaminal epidural steroid injection, which was performed on October 31, 2006.

On November 7, 2006, the Petitioner was involved in an unrelated motor vehicle accident. The Petitioner testified that she was hit while making a U-turn and suffered *left* upper trapezius muscle pain and *left-sided* neck pain, neither of which exacerbated the right-sided neck pain she was experiencing from her work injury. The Petitioner testified that there was no injury to her right upper extremity in this automobile accident.

On November 13, 2006, Petitioner attended physical therapy with OccuSport and the therapist noted that Petitioner's recent motor vehicle accident affected the left upper trapezius and had no effect on the work-related right side. It was noted that the Petitioner reported an overall improvement in her right-sided symptoms since her epidural injection on October 31, 2006. On November 14, 2006 Dr. Couri noted that the motor vehicle accident caused left scapular/shoulder-area spasms and increased left sided neck pain, but that her right-sided neck pain did not become any worse. He allowed Petitioner to continue working full duty.

Dr. Couri performed additional injections to the right C2-3, C5-6, and C6-7 zygapophyseal joints on December 19, 2006. Petitioner continued therapy.

On February 2, 2007, Petitioner saw Dr. Couri again and he recommended that Petitioner continue full time work but to do one-third less cases, and to instead spend that time doing something like teaching which she had done in the past. Dr. Couri ordered another EMG/NCV test of the right arm and an elbow injection.

An MRI arthrogram of the Petitioner's right shoulder was performed on June 14, 2007 at Future Diagnostics Group and was reported to be unremarkable.

The Petitioner was then referred by Dr. Couri to Dr. Giridhar Burra at Hinsdale Orthopedic Associates on June 22, 2017. Dr. Burra noted several positive physical exam findings relative to the right shoulder. Dr. Burra reviewed diagnostics and made a diagnosis of biceps tendinitis and a possible superior labrum anterior and posterior lesion. Dr. Burra recommended a diagnostic right shoulder arthroscopy.

On July 16, 2007, Petitioner returned to Dr. Couri who agreed with Dr. Burra's plan of diagnostic right shoulder arthroscopy. Dr. Couri stated that "it appears all of her symptoms came about with chronic repetitive work and lifting of heavy objects, and I believe that her right shoulder is the main cause of her symptoms which has exacerbated the neck and now the elbow." Dr. Couri placed Petitioner on 10 lbs. lifting restrictions and no overhead work.

On August 1, 2007, Petitioner was involved in another unrelated motor vehicle accident. She was taken to Silver Cross Hospital and complained of a left upper arm abrasion, a right shoulder abrasion, and mid lower back pain. The Petitioner testified that she only experienced slight soreness on her left side as a result of this accident.

On September 21, 2007, Dr. Burra authored a letter indicating that Petitioner's right shoulder/bicep symptoms preceded the motor vehicle accident and that she never had relief of symptoms prior to the motor vehicle accident. Accordingly, Dr. Burra opined that her shoulder symptoms were primarily related to her work injury and did not believe that the motor vehicle accident caused the injury.

On June 4, 2008, the Petitioner underwent right shoulder surgery at Silver Cross Hospital with Dr. Burra. The post-operative diagnosis was a SLAP lesion, subacromial bursitis and mild impingement in the right shoulder. The procedure consisted of right shoulder arthroscopy, SLAP lesion repair and subacromial decompression. Following surgery, Petitioner continued following up with Dr. Burra and performing physical therapy.

On November 19, 2008, the Petitioner reported to Dr. Burra that her right shoulder was doing well with increasing motion. However, she had a complaint on this date of rather extreme exacerbation of left elbow epicondylitis. She was diagnosed with left lateral epicondylitis. Dr. Burra recommended therapy for both the right shoulder and left elbow, and to remain restricted at work.

On January 7, 2009, Dr. Burra noted that Petitioner had made great progress with the right shoulder and could discontinue therapy and progress to a home exercise program. Dr. Burra placed Petitioner on restrictions for the right shoulder of no lifting greater than 25 lbs. and recheck in 6 weeks. Relative to the left elbow, Petitioner still complained of left elbow pain, worse with any gripping or lifting. Dr. Burra recommended a cortisone injection and continuation of physical therapy. The injection was done on this date. Dr. Burra also placed restrictions of no gripping with the left arm.

On April 17, 2009, Dr. Burra noted that Petitioner was pretty much asymptomatic for the right shoulder. He placed Petitioner at maximum medical improvement for her right shoulder and allowed her to return to full duty without restriction. However, for her continued right elbow symptoms, Dr. Burra noted that Petitioner had previous complaints suggestive of ulnar neuritis. He also noted that people with shoulder surgeries are at a higher risk because of the significant amount of flexion with performance of the rehab and immobilization after shoulder surgery, and this would put this condition for an exacerbation. He diagnosed ulnar nerve neuropathy and recommended a night splint. For the left elbow, Dr. Burra performed another injection and discussed possible surgical intervention if not improved. She was returned back to work with restrictions of no gripping with the left hand.

On June 25, 2009, the Petitioner saw Dr. Burra and reported that she was symptomatic in regard to her right elbow, complaining of paresthesia to the right ulnar nerve distribution. She was also tender over the left lateral epicondyle in the left elbow. Dr. Burra stated that "her right shoulder pathology [was] related causally to her right elbow symptoms..." For the left elbow lateral epicondylitis, he stated it is not a traumatic condition but an overuse syndrome. Dr. Burra discussed surgical options and recommended an MRI of the left elbow. A left elbow MRI was performed on July 9, 2009 at Future Diagnostics Group.

Dr. Burra reviewed the MRI of the left elbow on July 29, 2009 and diagnosed left epicondylitis. However, Petitioner reported improvement in her symptoms, and wanted to defer any surgical intervention unless symptoms worsen. Dr. Burra allowed her to continue to work with limitations of no repetitive gripping in the left hand, and to follow-up as needed.

On August 1, 2009, the Petitioner returned to Dr. Mirkovic for neck and right shoulder pain, and he ordered an MRI of the cervical spine and an EMG/NCV of the right upper extremity.

The Petitioner returned to Dr. Burra on December 2, 2009 complaining of increased right shoulder pain that freezes, cracks and pops, as well as increased pain with overhead activities or reaching behind or across her body. Dr. Burra diagnosed right elbow lateral epicondylitis as well as cubital tunnel syndrome. He recommended a repeat MRI arthrogram, and also to return after the EMG was done relative to the right elbow.

The Petitioner returned to Dr. Burra on January 6, 2010. Despite a negative EMG, Dr. Burra felt that the Petitioner had left elbow cubital tunnel syndrome and recommended ulnar nerve transposition surgery. For the right elbow, he diagnosed lateral epicondylitis, and recommended conservative treatment. Relative to the right shoulder, the MRI arthrogram showed some post-

surgical changes, but Dr. Burra recommended trying to manage it conservatively. The Petitioner was kept on restrictions of no repetitive gripping and no lifting greater than 5 lbs.

On July 2, 2010, the Petitioner had another EMG with Dr. Wayne Kelly of Health Benefits Pain Management. The EMG was noted to be abnormal, and the impression was 1) a right-sided chronic underlying chronic C6-7 cervical radiculopathy with evidence of primarily chronic axonal involvement; 2) a superimposed right-sided mild chronic compression/entrapment ulnar neuropathy across the elbow (Cubital tunnel syndrome) with evidence of mild focal demyelination and mild chronic axonal involvement, likely indicative of a double crush injury; 3) a bilateral moderate chronic compression/entrapment median mono neuropathies at the wrist (carpal tunnel syndrome) with evidence of moderate focal demyelination of both sensory and motor nerves as well as chronic axonal involvement; 4) no electrophysiological evidence of an underlying sensory/motor polyneuropathy or right brachial plexopathy. Dr. Kelly recommended two C6-7 cervical injections, a right ulnar nerve steroid block along the ulnar nerve, and a right distal medial nerve steroid block at the carpal tunnel and use of cock-up wrist splints.

Claim Number 10 WC 39044

The Petitioner testified that on August 2, 2010, she was injured for a sixth time when working on a case with several kilos of plant material wrapped in multiple layers of saran wrap. The Petitioner testified that she was using an X-acto knife to cut open the packages and enter the information into the computer. By the time she was done analyzing, sampling, and repackaging, her right and left hands, wrists, and thumbs were in significant pain.

The Petitioner reported the incident to her supervisor and an accident report was eventually completed. The Petitioner reported in the accident report that she was opening packaged kilos of cannabis. She had to cut open the package and remove the cannabis for weight and analysis. During these job duties, she felt pain in her right wrist, right elbow, left wrist, and bilateral hands. Timely notice of this injury is not disputed.

On August 16, 2010, the Petitioner returned to Dr. Burra, and she reported that her right shoulder pain was significantly resolved, and her left elbow pain was improved. She complained, however, that she was very limited and affected by her right elbow pain. She reported the recent work activity of opening multiple kilo packs which involved significant flexion/extension across her right elbow and had worsened her symptoms. Dr. Burra reviewed the EMG from July 2010. Dr. Burra indicated that Petitioner had a double crush condition. Dr. Burra recommended ulnar nerve transposition surgery.

Surgery was performed on September 28, 2010 to the right elbow. The pre-and-post operative diagnosis was ulnar nerve compression neuropathy of the right elbow. The procedure performed consisted of right-side ulnar nerve anterior transposition with a subcutaneous technique. Petitioner was placed on sedentary work/paperwork only duties.

Petitioner continued following-up with Dr. Couri in 2010 and did physical therapy for the post-operative right elbow.

On November 17, 2010, Dr. Burra recorded that Petitioner's numbness and tingling in her right 4th and 5th fingers was resolving post-surgery. Her left elbow was asymptomatic as of this date. Dr. Burra placed Petitioner on continued work restrictions.

On December 28, 2010, Dr. Burra noted that the Petitioner's right 4th and 5th finger symptoms had resolved. Her right elbow was doing much better. Noting that the Petitioner's right elbow, right shoulder, and left elbow symptoms were under control, Dr. Burra released her from his care. Dr. Bura indicated that the Petitioner was able to return to work relative to the right elbow, right shoulder and left elbow, but he noted that the Petitioner was still treating with Dr. Couri for carpal tunnel syndrome.

The Petitioner continued treatment with Dr. Couri in early 2011 for bilateral carpal tunnel syndrome. On January 10, 2011, she complained of bilateral hand symptoms which were improving. She still had a complaint of left elbow pain at this visit and she reported that her work aggravated both conditions. Dr. Couri kept Petitioner on work restrictions.

On March 25, 2011, Dr. Couri performed a left eblow lateral epicondyle injection, and instructed Petitioner to continue using a cock-up wrist splint. She was kept on work restrictions. On April 19, 2011, Dr. Couri recommended another cervical MRI, and kept Petitioner on work restrictions.

On May 23, 2011, Dr. Couri reviewed the April 26, 2011 MRI. Petitioner reported doing better with the left elbow pain since the injection. She was still having mild left lateral elbow pain and left sided neck pain. Dr. Couri recommended left C6 and C7 transforaminal epidural steroid injections and physical therapy, which Petitioner wanted to defer for the time being. She would instead try a home traction unit for one to two weeks first. She was kept on work restrictions. Dr. Couri performed an additional left elbow injection on August 2, 2011.

The Petitioner continued following up with Dr. Couri in 2012. By October 1, 2012, Dr. Couri noted that Petitioner had bilateral wrist pain and weakness. She reported numbness and tingling with fine motor activities, and also decreased grip. Dr. Couri's diagnoses was bilateral moderate carpal tunnel syndrome. He discussed bilateral percutaneous carpal tunnel release surgery in the future. She was kept on work restrictions.

On October 26, 2012, Petitioner underwent bilateral *percutaneous* carpal tunnel release surgeries with Dr. Couri.

She returned to Dr. Couri on December 6, 2012 who noted that the carpal tunnel releases had failed. He referred the Petitioner to Dr. John Fernandez at Midwest Orthopedics at Rush for another opinion.

The Petitioner saw Dr. Fernandez for the first time on January 9, 2013, and he diagnosed the Petitioner with bilateral carpal tunnel syndrome, bilateral thumb CMC joint osteoarthritis, and bilateral upper extremity pain. He recommended bilateral carpal tunnel release procedures.

On February 8, 2013, Petitioner underwent left wrist carpal tunnel release with Dr. John Fernandez. On February 25, 2013, Dr. Fernandez noted that Petitioner's paresthesias in the left hand had nearly completely resolved.

On April 12, 2013, Petitioner underwent right wrist carpal tunnel release surgery with Dr. Fernandez. Petitioner saw Dr. Fernandez on April 29, 2013, who noted improvement after right wrist surgery relative to numbness and tingling. Her main complaint on this day was pillar pain primarily worse on the right than left, worse with direct pressure of the palm and also worse with lifting activities. Dr. Fernandez noted that Petitioner could work with restrictions until June 1, 2013 at which time she would be at maximum medical improvement and able to return to full duty work.

The Petitioner testified that she lost one day of work for each carpal tunnel surgery and that the Respondent continued to accommodate her restrictions. She testified that she did less repetitive work and she participated in more teaching activities at work.

The Petitioner continued to work on restricted duty until May 31, 2013 when she voluntarily retired from her employment with the State of Illinois.

On May 27, 2015, the Petitioner returned to Dr. Fernandez with complaints of a bump/nodule on her left palm which was slightly tender to palpation and bothered her when performing gripping and working out activities. Relative to the right upper extremity, she complained of volar wrist pain. Her neurologic complaints from the median nerve distribution were completely resolved at this point. Dr. Fernandez performed a physical exam which noted a slight thickening of the surgical site along the left palm, and also a Dupuytren's nodule associated with the middle finger of the left palm. Relative to the right wrist, she had very minimal swelling along the volar aspect. She had full range of motion of the hand, wrist, and elbow. X-rays were performed which revealed ulnar positive variance by approximately 2mm. Dr. Fernandez' diagnoses were 1) left hand Dupuytren's disease, nodular phase; 2) bilateral upper extremity pain beginning while working as a chemist in 2012. Some medications were prescribed, and she was told to follow-up as needed.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

The Petitioner was examined at the request of her attorney by Dr. Samuel Chmell on October 15, 2015. Dr. Chmell's deposition testimony was admitted into the record as Petitioner's Exhibit 20. Dr. Chmell testified as to his understanding of the Petitioner's job duties and work history as well as her history of injuries and his examination findings. Dr. Chmell made the following seven diagnoses for the Petitioner: 1) bilateral carpal tunnel syndrome and multiple tendinitis, both wrists status post bilateral carpal tunnel releases times two; 2) right elbow cubital tunnel syndrome, status post ulnar nerve decompression and anterior transposition; 3) right shoulder SLAP lesion and impingement

syndrome, status post arthroscopy SLAP repair and subacromial decompression; 4) right shoulder snapping scapula syndrome; 5) bilateral elbow lateral and medial epicondylitis; 6) traumatic aggravation of degenerative disc disease in cervical spine with right upper extremity radiculopathy; and 7) right thoracic outlet syndrome.

Relative to causation, Dr. Chmell testified as to each of his seven diagnoses:

Relative to the bilateral carpal tunnel syndrome/multiple tendonitis hands and wrist, status post bilateral carpal tunnel release times two, Dr. Chmell testified that these conditions are causally related to Petitioner's work accidents of January 9, 1996, February 8, 2000, July 3, 2001, and August 2, 2010. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right cubital tunnel syndrome, status post ulnar nerve decompression and anterior decompression and interior transposition, Dr. Chmell testified that this condition was causally related to the July 3, 2001 and the August 2, 2010 work accidents. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right shoulder SLAP lesion and impingement syndrome status post arthroscopy, SLAP repair and subacromial decompression, Dr. Chmell testified that this condition was causally related to the work accident of November 25, 2003, which was aggravated on November 3, 2005. Dr. Chmell testified that this injury was a result of Petitioner's repetitive activities at work and that all treatment for those conditions to date has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right shoulder snapping scapular syndrome, Dr. Chmell testified that this condition is causally related to the November 25, 2003 work accident which was later aggravated during the November 3, 2005 work accident. Dr. Chmell testified that all treatment for this condition was reasonable, necessary, and causally related to the work accidents.

Relative to the diagnosis of bilateral elbow lateral and medial epicondylitis, Dr. Chmell testified that the right arm condition was causally related to the July 3, 2001 work accident and was further aggravated by the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell testified that the left elbow condition became involved after the August 2, 2010 work accident. Dr. Chmell opined that all treatment to date for these conditions has been reasonable, necessary, and related to the work accidents.

Relative to the diagnosis of cervical spinal traumatic aggravation of degenerative disc disease with right upper extremity radiculopathy, Dr. Chmell testified that this condition was causally related to the work accident of February 8, 2000, and further aggravated by the July 3, 2001, November 3, 2005, and August 2, 2010 work accidents. The condition was confirmed by positive EMG findings following the November 3, 2005 work accident. Dr. Chmell opined that all treatment to date for this condition has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right thoracic outlet syndrome, Dr. Chmell testified that this condition was causally related to the February 8, 2000 work accident, which was later aggravated during the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell opined that all

treatment for this condition to date has been reasonable, necessary, and related to the work accidents.

Dr. Chmell reviewed several accident reports which were included in Petitioner's Deposition Exhibit #4 at the deposition and noted that Petitioner's job duties as described in the reports are consistent with the type of activity that could cause the conditions he diagnosed.

Dr. Chmell opined that as of the date he saw Petitioner on October 15, 2015, Petitioner was at maximum medical improvement. Dr. Chmell also opined that Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma. Finally, Dr. Chmell testified that Petitioner's work restrictions in this case have been related to her work injuries.

Dr. Chmell testified that he disagreed with Dr. Verma's conclusion that the Petitioner's work was not consistent with a mechanism to cause A-C joint arthrosis or biceps tendon superior labral tearing. Dr. Chmell opined that repetitive motion activities can affect the shoulder when the labrum is stressed and eventually shreds and tears. Dr. Chmell further disagreed with Dr. Verma's conclusion that Petitioner reached MMI on March 17, 2008. Dr. Chmell disagreed because he believed Petitioner's shoulder surgery on June 4, 2008 helped her condition.

At the request of the Respondent, the Petitioner was examined by Dr. Nikhil Verma on March 17, 2008 and April 17, 2017 and he performed a record review on January 10, 2018. Dr. Verma's April 4, 2018 deposition testimony was admitted into the record as Respondent's Exhibit 20.

With regard to his examination of the Petitioner on March 17, 2008, Dr. Verma testified that he examined the Petitioner and reviewed the Petitioner's medical records from 2002 through 2007. Dr. Verma testified that he didn't review a written description of the Petitioner's job duties in preparation for the exam but the Petitioner described to him that her work as a forensic scientist involved using her hands for fine work, including opening small packages and testing substances and powders. Dr. Verma's diagnosis was right upper extremity pain with possible cervical spondylosis and radiculopathy. Dr. Verma did not believe this to be causally related to her job duties, because he did not locate a diagnosis within the shoulder that would be responsible for her symptoms, which he viewed to be diffuse in nature and not explained by the Petitioner's AC joint, biceps, or SLAP problems. Dr. Verma further testified that a repetitive use type mechanism is not consistent with a SLAP pathology in an individual of the Petitioner's age group.

Dr. Verma stated that degenerative changes in the labrum are common for patients in Petitioner's age group, and that the only repetitive use mechanism that generates SLAP tears is throwing a baseball at 80-plus miles per hour, which is not an activity in which he believed Petitioner was participating. Dr. Verma stated that repetitive work would be similarly inconsistent with superior labral pathology. Dr. Verma did not believe that the Petitioner's clinical exam findings supported the diagnosis of superior labral pathology, given their diffuse nature involving multiple components of her upper extremity.

Dr. Verma opined that Petitioner did not require any additional medical treatment for her shoulder related to a work injury, did not require any work restrictions, and was at maximum medical improvement.

With regard to his examination of the Petitioner on March 17, 2017, Dr. Verma testified that he reviewed the Petitioner's medical records from Dr. Burra, pain management records, records from Hinsdale Orthopedics, and records from Dr. Chmell. Dr. Verma noted that Petitioner's bilateral shoulders were normal aside from healed incisions on the right side and he indicated that the Petitioner demonstrated full range of motion, normal cervical motion, normal neurovascular systems, and no provocative testing findings on either shoulder. Dr. Verma opined that the Petitioner's right shoulder was essentially normal both objectively and subjectively. She had undergone right shoulder SLAP repair, which Dr. Verma did not believe was causally related to the work activities. Dr. Verma also opined that Petitioner was at maximum medical improvement for the shoulders, that no additional treatment was needed, and that she did not require any work restrictions relative to the shoulders.

With regard to his review of additional medical records of the Petitioner's treatment from 1996 through 2010, Dr. Verma testified that he also reviewed a job description in conjunction with authoring this report. Following his review of the updated records, Dr. Verma diagnosed the Petitioner with chronic upper extremity pain with possible fibromyalgia-type symptoms. Dr. Verma again stated that he did not believe Petitioner's condition to be causally related to her job duties.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

After reviewing all testimony and evidence, the Arbitrator hereby finds that the Petitioner did sustain accidents that arose out of and in the course of her employment by the Respondent on January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010. The accidents are supported by the Petitioner's testimony and corroborated by the accident reports and the treating medical records.

The respondent did not call any witnesses to dispute the Petitioner's version of her job duties or how the accidents occurred.

With regard to the issue of Notice, the Arbitrator notes that the Respondent only disputed the issue of timely notice with regard to the initial injury of January 9, 1996 (Claim Number 04 WC 13698). Based upon the Petitioner's unrebutted testimony, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Several of Petitioner's treating physicians provided opinions as to causation in this case over the years.

On March 27, 1996, while referring to Petitioner's soft tissue/tendons in the right forearm, Dr. Brannegan noted that "it sounds as if [Petitioner's] work demands a fair amount of repetitive fine hand movement, and this probably aggravates this problem."

Dr. Bayliss indicated in February and March of 2000 that Petitioner's symptoms are related to the ergonomics of her workstation and recommended altering the workstation.

Kurt James Keppner, D.C. noted on April 28, 2000 that Petitioner's condition has deteriorated over the last four months caused by her overuse at an ergonomically unsound workstation that places undue stress and strain on her neck and upper back.

On May 30, 2002, Dr. Shea at Loyola noted that "working aggravates all of her symptoms" while discussing Petitioner's neck, right arm, right thumb and grip strength.

On June 18, 2002, Dr. Bednar noted "I believe the work that she does aggravates her current condition." He also ordered her workstation be modified.

On February 6, 2004, Dr. Charles Carroll at Northwestern noted "[Petitioner] has an ongoing problem which has been further aggravated by her more recent work stress" while discussing a possible diagnosis of neuritis of the upper extremity. On February 26, 2004, Dr. Carroll stated, "I have considered her present condition of ill-being to be aggravated by the work that she discussed in previous correspondence."

Dr. Burra at Hinsdale Orthopedics stated on August 16, 2001 that "while the shoulder per se does not cause her ulnar nerve symptoms at the elbow... I have seen incidence or worsening of cubital tunnel syndrome following shoulder surgery because of the degree and duration of flexion that is required across the elbow both in the immediate postoperative period while she is in the sling as well as during the course of rehabilitative exercise and physical therapy following shoulder surgery, and I have seen this in my practice where there is an aggravation of this. As such, there is some relationship between her shoulder surgery and her elbow symptoms."

Dr. Burra also opined as to causation for the right shoulder SLAP lesion and biceps tendinitis in his September 21, 2007 correspondence. In this note, Dr. Burra opined that there is a clear-cut causal relationship of the work injury of November 3, 2005 to the right shoulder condition. He ruled out the auto accident as a cause of her condition.

Dr. Samuel Chmell, who examined the Petitioner at her attorney's request, testified that the sum of all the Petitioner's job duties involved repetitive stressful and difficult movements of Petitioner's upper extremities, right greater than left. He testified that the Petitioner did these tasks for 32 years, which was significant because her job duties subjected her upper extremities to repetitive motion activities, which is akin to overuse activities. Dr. Chmell testified that the Petitioner's job duties are consistent with the type of activity that could cause the conditions diagnosed in this case.

Dr. Chmell found seven diagnoses, which he opined were causally related to one or more of the work accidents in this case. Dr. Chmell noted that the Petitioner did not have any problems with her neck or upper extremities prior to working as a forensic chemist for the Respondent. Dr. Chmell

opined that the following seven diagnosed conditions were causally related to the Petitioner's work accidents:

1) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Nikhil Verma, the Respondent's examining physician, opined that Petitioner's diagnosis was chronic upper extremity pain with possible fibromyalgia-type symptoms. He did not feel that these conditions were causally related to her job duties. Dr. Verma only evaluated Petitioner relative to her bilateral shoulders and he did not evaluate her for any other body parts or conditions.

After reviewing all of the medical records, testimony and evidence, the Arbitrator finds the causation opinions of Petitioner's treating doctors to be consistent with the evidence and persuasive. The opinions and testimony of Dr. Samuel Chmell are credible and well-founded. Dr. Chmell's opinions correlate with those of Petitioner's treating doctors. Dr. Chmell also understood Petitioner's job duties consistent with Petitioner's testimony. While the Arbitrator notes the findings and opinions of Dr. Verma, the Arbitrator finds the causation opinions of the Petitioner's treating physicians, including Drs. Brannnegan, Carroll, Bayliss, Keppner, Shea, and Bednar to be persuasive. The Arbitrator also finds the opinions of Dr. Sam Chmell to be sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's work injuries on January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

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:

At trial, Petitioner submitted evidence of unpaid medical bills totaling $58,148.92, as summarized in Petitioner's Exhibit 31. Dr. Chmell testified that all medical treatment rendered to the Petitioner for her diagnosed conditions was reasonable, necessary, and causally related to the work accidents in this case. The Arbitrator hereby adopts the opinions of Dr. Chmell, which are sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof and finds that the unpaid medical bills totaling $58,148.92 set forth in Petitioner's Exhibit 31 are reasonable, necessary, and causally related to the work accidents of January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Additionally, the Petitioner submitted evidence of out-of-pocket travel/mileage costs as summarized in Petitioner's Exhibit 31. Section 8(a) of the Act states that the employer shall pay for treatment, vocational rehabilitation, and all services reasonably required to cure or relieve the effects

of the accidental injury. 820 ILCS 305(8)(a). Travel expenses are awarded in cases where it was reasonably necessary for the petitioner to travel in order to receive medical treatment. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). Here, the Petitioner's travel for treatment from 1996 through 2012 was for physical therapy, doctor's appointments, and testing, which all constitute reasonable travel expenses under the law. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate.

The Petitioner's mileage for travel to and from medical appointments as submitted in Petitioner's Exhibit 31 totals 17,629 miles. Applying the appropriate "IRS medical" rate applicable at the time of the travel, results in the total amount of $2,841.00 due. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate in the amount of $2,841.00.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she underwent surgery to her right shoulder on June 4, 2008 and that she was off work as a result of that surgery through July 29, 2008, a period of 8 weeks. The Petitioner testified that she underwent surgery to her right elbow on September 28, 2010 and that she was off work as a result of that surgery through October 2, 2010, a period of 5/7 weeks. The Petitioner underwent surgery to her left and right hands on February 8, 2013 and April 12, 2013, respectively, and that she was off work for one day after each of those surgeries, a period of 2/7 weeks. Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits for the periods of June 4, 2008 through July 29, 2008, a period of 8 weeks, September 28, 2010 through October 2, 2010, a period of 5/7 weeks, February 8, 2013, a period of 1/7 weeks, and April 12, 2013, a period of 1/7 weeks.

While the Petitioner claimed to be entitled to Temporary Partial Disability benefits for the hours of work that she missed obtaining treatment and therapy, the Arbitrator finds that the Petitioner failed to provide sufficient specific evidence of the actual periods of disability to allow the calculation of the exact amount of Temporary Partial Disability benefits that may be due, if any. The Arbitrator finds, therefore, that the Petitioner failed to meet its burden of proof with regard to what Temporary Partial Disability benefits, if any, are due. Accordingly, no Temporary Partial Disability benefits are awarded herein.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that Dr. Fernandez, the last physician who treated the Petitioner, noted that the Petitioner would be at maximum medical improvement by June 1, 2013 at which time she would be able to return to full duty work.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into

the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

Dr. Chmell, who examined the Petitioner at the request of her attorney on October 15, 2015, found seven diagnoses, which he opined were causally related to one or more of the Petitioner's work accidents:

2) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Chmell opined that the Petitioner was at maximum medical improvement. Dr. Chmell also opined that the Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a cumulative result of the Petitioner's six work injuries the Petitioner sustained permanent partial disability to her whole person to the extent of 27% thereof.

In Support of the Arbitrator's Decision relating to (N.), Is Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent claimed a credit under Section 8(j) of $17,894.58 (04WC13699); $3,955.04 (04WC13736); $33,044.57 (06WC6834). Respondent entered exhibits #13, 14, and 15 in support of their alleged 8(j) credit. Petitioner disputed the Respondent's entitlement to an 8(j) credit at the time of arbitration.

However, after the hearing on June 4, 2019, the parties entered into a stipulation on June 5, 2019 wherein they agreed that "the payments made by the Respondent referred to and contained in Respondent's exhibits 13, 14, and 15 were made by the workers' compensation claims department who administers, pays, and adjusts workers' compensation claims for the State of Illinois. The State

of Illinois is a self-insured employer under the Illinois Workers' Compensation Act. They are not payments made by a group insurance carrier."

The Arbitrator finds that the Respondent is entitled to credit for all of the 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	10WC039044
Case Name	RIZO, AURELIA v. ILLINOIS STATE POLICE-
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0204
Number of Pages of Decision	25
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Danielle Curtiss

DATE FILED: 4/21/2021

21IWCC0204

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

Aurelia Rizo,

Petitioner,

vs. NO: 10 WC 39044

Illinois State Police – Crime Lab,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 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: 4/21/2021

MP:yl
o 4/15/21
68

/s/ *Marc Parker*

/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0204

RIZO, AURELIA
Employee/Petitioner

Case# **04WC013698**

04WC013699
04WC013700
04WC013736
06WC006834
10WC039044

ILLINOIS STATE POLICE-CRIME LAB
Employer/Respondent

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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
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

JUL 31 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aurelia Rizo
Employee/Petitioner

v.

Illinois State Police – Crime Lab
Employer/Respondent

Case # **04** WC **13698**

Consolidated cases: **04 WC 13699, 04 WC 13700, 04 WC 13736, 06 WC 6834, 10 WC 39044**

An *Application for Adjustment 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 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. ☒ Did an accident 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 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent

On each of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**94,885.96**; the average weekly wage was $**1,824.73**.

On the dates of accident, Petitioner was **36, 40, 42, 43, 45, and 50** years old, respectively, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,216.49**/week for **9** weeks, commencing **June 4, 2008 through July 29, 2008, September 28, 2010 through October 2, 2010, February 8, 2013, and April 12, 2013**, as provided in Section 8(b) of the Act

Respondent shall be given a credit for all temporary total disability benefits that have been paid

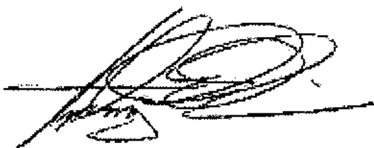
Respondent shall pay reasonable and necessary medical services of $**60,989.92**, as provided in Sections 8(a) and 8.2 of the Act

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

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **135** weeks, because the injuries sustained caused the **27%** loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

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



Arbitrator Anthony C. Erbacci

JUL 3 1 2019

July 23, 2019
Date

FACTS:

The Petitioner testified that she became employed by the Respondent as a forensic scientist on April 1, 1982 and that she continued in that employment until she retired on May 31, 2013. The Petitioner described her job duties as requiring repetitive fine motor skills and the use of a computer. Specifically, she described that she was required to cut open packages of drugs for analysis, and to input her findings into a computer. The Petitioner described that she would run tests to identify the contents of multiple items in each case, some containing up to several hundred individual pieces. These items were most often in multiple small bags or in large, wrapped packages. The Petitioner testified that she would open the items packaged in small bags using forceps and tweezers, and then sample them for testing using a spatula the thickness of a USB cord. The items packaged in large bags were often wrapped in 3-5 layers of plastic, duct tape, oil, and dryer sheets, which the Petitioner would have to cut through with an X-acto knife in order to sample and weigh the materials inside.

The Petitioner testified that she would weigh all specimens individually, take samples and place them into small glass vials the size of a fingernail, or pipette the samples using a dropper bottle. The vials the specimens were placed into needed to be crimped and uncrimped with a squeezing motion so they could be tested. The Petitioner testified that she also frequently used pliers, scissors, pens, scalpels, and X-acto knives with her right hand. The Petitioner testified that her work also involved squeezing a manual scanner to sign in evidence and carrying boxes of evidence from the evidence storage area to her workstation.

The Petitioner claims to have been injured six times during the course of her employment with the Respondent: first on January 9, 1996, then on February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Claim Number 04 WC 13698

The Petitioner testified that on January 9, 1996, she was working on a multi-item drug case that required her to open tiny bags with forceps and tweezers, sample each item with a spatula, and follow the protocol required for each case: weigh the sample, take a sample of one set using a dropper bottle for a color test, take another sample, dilute it, and place it into an instrument using a capper, and then type the information into the computer and repackage and mark every single item. The Petitioner testified that by the time she was done with this particular case, her right hand had turned purple and cold to the touch, and she had pain in her right forearm all the way up to her right shoulder and neck. The Petitioner testified that her arm was in such pain that she had difficulty pushing a door open to leave the room. The Petitioner testified that she told her direct supervisor, Sally Dillon, about the incident and her pain.

A "Supervisor's Report of Injury or Illness" was eventually completed by Sally Dillon on May 2, 1996. In this report, it is noted that on January 11, 1996 the Petitioner reported an injury on January 9, 1996 when she experienced intense pain in her right wrist area, thumb, palm and forearm while taking samples of evidence.

The Petitioner testified that she continued to work following that incident and then sought treatment from Dr. Richard Brannegan for her right shoulder, arm and hand pain. A March 27, 1996 letter report from Dr. Brannegan, addressed to Dr. John Olivieri at Meyer Medical, was admitted into

the record as Petitioner's Exhibit 4. The Arbitrator notes that no records of treatment from Dr. Olivieri were offered into evidence. In his report, Dr. Brannegan noted that the Petitioner likely had an overuse syndrome with pain in the right hand and wrist coming from local sources such as the tendons and soft tissues of the forearm. Dr. Brannegan also noted that Petitioner's work demanded a fair amount of repetitive fine hand movement which aggravated the problem. He recommended some anti-inflammatory medications, splinting of the hand, and physical therapy.

On July 9, 1996, it was noted that the Petitioner then attended 13 sessions of physical therapy for thoracic outlet syndrome at HealthSouth, which were apparently prescribed by Dr. Olivieri. On July 8, 1997, the Petitioner underwent a Functional Capacity Evaluation at Health South which indicated that Petitioner could work in the medium demand level and perform all activities of her job.

Claim Number 04 WC 13699

The Petitioner testified that on February 8, 2000, she was injured for a second time when working several multiple-item drug cases on the same day. The Petitioner testified that, for each item in each case, she would follow the same steps to test, inventory, repackage, and mark the exhibit. She testified that by the end of the day, her right hand was purple and tingling with severe pain through her wrist and arm. A "Notice of Injury" form was completed on February 22, 2000 wherein the Petitioner reported an injury to her right hand, right wrist, neck, right shoulder, and right forearm. Timely notice of this injury is not disputed.

Following the February 8, 2000 injury, the Petitioner sought treatment with Dr. William Baylis at Parkview Musculoskeletal Institute on February 29, 2000. Petitioner complained of four to five years of right-hand medial elbow pain radiating to her right side of her neck, and also noted the poor ergonomic environment of her job and her job duties. Dr. Baylis prescribed a custom forearm splint and an EMG test which was performed on March 8, 2000 and reported to be normal study. On March 16, 2000, Dr. Baylis ordered an ergonomically correct workstation for Petitioner and limited her repetitive motion to four hours out of an eight-hour workday.

The Petitioner then sought treatment with a chiropractor, Kurt James Keppner, D.C. Dr. Keppner's impression was that the Petitioner sustained a repetitive motion injury to the cervico-thoracic spine, and he recommended chiropractic care.

On November 20, 2000, the Petitioner was examined by Dr. Michael Bednar at the request of the Respondent. Dr. Bednar's impression was that Petitioner likely had a variant of thoracic outlet syndrome. He agreed with Dr. Baylis' plan for improving Petitioner's ergonomic work situation. He opined that additional physical therapy and chiropractic manipulation would not improve her condition and that she would not benefit from surgery. Dr. Bednar indicated that the Petitioner was not at a level of maximal medical improvement, and he recommended that she get an ergonomically improved workstation and continue with Dr. Baylis' restrictions of limiting repetitive work to only 50 percent of Petitioner's workday.

On April 24, 2001 Dr. Bednar noted that some ergonomic changes had been made to the Petitioner's workstation which she felt had improved some of her symptoms. On June 1, 2001Dr. Bednar noted that an MRI of the Petitioner's cervical spine had been completed and demonstrated

som mild stenosis at C6-7. Dr. Bednar then referred the Petitioner to Dr. Alexander Ghanayem at Loyola.

On June 27, 2001, the Petitioner saw Dr. Ghanayem who indicated that her MRI findings were incidental and did not correlate with her symptoms. Dr. Ghanayem did not believe that the Petitioner had a cervical spine etiology for her right upper extremity symptoms.

Claim Number 04 WC 13700

The Petitioner testified that on July 3, 2001, she was injured for a third time. The Petitioner testified that, for some time, she had been breaking up her day to avoid repetitive tasks but, on this date, she was working on a case where 14,055 grams of plant material were wrapped in layers of saran wrap, duct tape, and dryer sheets. The Petitioner testified that she cut the package open with a scalpel and X-acto knife, sampled it, and repackaged it. She testified that while repackaging the item, she experienced extreme pain in her right hand, wrist, fingers, arm, shoulder, neck and elbow.

A "Notice of Injury" form was eventually completed in which the Petitioner described an injury to her right hand which felt numb, cold, and tingly. She also reported that her right arm and right wrist area hurt the entire day and evening, and her right hand, right wrist, neck and right shoulder ached for several days. Timely notice of this injury is not disputed.

Following the July 3, 2001 injury, the Petitioner returned to Dr. Bednar at Loyola on August 14, 2001. Dr. Bednar noted that the Petitioner's symptoms were now more significant for numbness and tingling in the median nerve distribution. Dr. Bednar placed Petitioner on a 20 lbs. work restriction and discussed a future EMG test. Petitioner was also sent for biofeedback and occupational therapy which was performed at Rehabilitation Institute of Chicago. The Respondent accommodated the Petitioner's physical restrictions.

On November 13, 2001, Petitioner returned to Dr. Bednar, who noted no point tenderness, and that Petitioner could return to work without restrictions. However, Dr. Bednar also told Petitioner to change her tasks over the day and not be as repetitive. Dr. Bednar placed Petitioner at maximum medical improvement on this date.

The Petitioner then saw Dr. John Shea, a neurosurgeon at Loyola, from March to May of 2002. Dr. Shea noted right sided neck pain radiating to the right arm and hand and tingling into the right hand. Dr. Shea reviewed Petitioner's cervical MRI and did not see evidence of thoracic outlet syndrome. He allowed Petitioner to continue to work with the restrictions of Dr. Bednar.

On June 18, 2002, Dr. Bednar saw Petitioner again and his current diagnosis was pain of the neck and arms which are of undefined etiology. Dr. Bednar referred Petitioner to Dr. William Sullivan at Loyola in the physical medicine and rehabilitation department, to see if there was any further treatment available for Petitioner. Petitioner was allowed to return to work full duty without restriction on June 19, 2002. Dr. Bednar did note that the Petitioner's symptoms increased during the workday and aggravated her current condition, and that it was difficult to determine when she would reach maximum medical improvement.

On July 17, 2002, the Petitioner saw Dr. Sullivan who noted a diagnosis of chronic pain likely of myofascial origin in the shoulder and scapular regions. Dr. Sullivan showed Petitioner exercises, prescribed medications, and stated she was at maximum medical improvement. Dr. Sullivan recommended Petitioner take breaks throughout the workday.

Claim Number 04 WC 13736

The Petitioner testified that on November 25, 2003, she was injured for a fourth time. The Petitioner testified that over several days, she worked on a drug case that contained 57 small item baggies. The Petitioner testified that for each item, she was required to open the bag, weigh the specimen, mark it, write down the weight, complete preliminary testing on the color of the specimen using a dropper bottle, take another sample with the spatula, clean it off, mark the vial, add a solvent, use a pipette to decant the liquid into another vial, then crimp or screw the cap on a vial and mark it. The Petitioner testified that she needed to take frequent breaks and do her prescribed stretching throughout the project. She testified that she completed the case successfully, but experienced excruciating pain from holding the scalpels, pens, scissors, and other small and thin tools. She testified that the pain was tingling and radiated from her right thumb and wrist up to her elbow, right shoulder, and right neck. She reported the injury to her supervisor.

An "Employer's First Report of Injury" form was eventually completed and indicated a work accident of November 25, 2003 from repetitive motion while Petitioner was opening 57 bags of specimens for analysis. The report mentioned right shoulder and neck pain.

On February 6, 2004, the Petitioner sought treatment with Dr. Charles Carroll. Dr. Carroll noted a history of Petitioner's significant workload that involved multiple bags of data, wherein she developed pain in the shoulder, elbow, and hand. She complained of pain in the right neck, right chest, subclavicular region anterior shoulder, and along the course of the ulnar nerve. Dr. Carroll noted numbness and tingling in the right hand consistent with carpal tunnel syndrome. Dr. Carroll noted that there was evidence of right thoracic outlet syndrome and mild evidence of left thoracic outlet syndrome. Her neurological exam also showed evidence of ulnar neuritis and carpal tunnel syndrome. Dr. Carroll also noted possible shoulder instability. He recommended physical therapy and an MRI. He also allowed Petitioner to continue working but to not do heavy lifting and to vary her job tasks.

The Petitioner participated in physical therapy and occupational therapy at Northwestern Center for Orthopedics. She also underwent an MRI of the right shoulder on February 12, 2004 at High Tech Medical Park which was a normal study.

On February 23, 2004, Petitioner returned to Dr. Carroll who reviewed prior medical records and diagnostic studies. Dr. Carroll noted several positive physical and neurological examination findings and indicated that Petitioner had evidence of neuritis at the ulnar nerve and carpal tunnel region, even in the face of normal electrodiagnostic studies. She also had evidence of possible cervical radiculitis. Dr. Carroll recommended continued physical therapy, and an MRI of the cervical spine. He allowed Petitioner to continue working but instructed her to vary her job duties. Dr. Carroll considered Petitioner's present condition of ill-being to be aggravated by the work that she does.

Petitioner continued therapy, but with OccuSport physical therapy, throughout March and April 2004. On March 20, 2004, the Petitioner underwent a cervical MRI at High Tech Medical Park.

On May 5, 2004, Dr. Carroll noted a diagnosis of cervical spondylosis based on the March 20, 2004 MRI. Dr. Carroll recommended that Petitioner see Dr. Srdjan Mirkovic for the cervical condition and indicated that he has not yet determined that the cervical spine is the sole cause of her arm pain. Dr. Carroll noted that the Petitioner was not at maximum medical improvement but could continue working exercising care with highly repetitive activities.

Petitioner saw Dr. Mirkovic at Northwestern on June 16, 2004. Dr. Mirkovic noted complaints of neck and right arm pain radiating to the elbow and occasionally the hand with right shoulder pain. Dr. Mirkovic opined that the Petitioner's current symptoms were an aggravation of a pre-existing cervical spondylosis and he recommended a CT myelogram of the cervical spine.

The CT Myelogram was performed on August 2, 2004. Dr. Mirkovic reviewed the CT myelogram on August 17, 2004 and noted foraminal stenosis on the right at C4-5 greater than C5-6. Dr. Mirkovic noted that some of Petitioner's symptoms may be emanating from nerve root compression secondary to the foraminal stenosis. He discussed possible surgical options and recommended right C5 and C6 nerve root blocks.

On October 20, 2004, Dr. Jeff Katz performed the cervical epidural steroid injection to Petitioner's right C5-6. He noted that Petitioner's neck and shoulder felt 50 percent better after the injection. Her thumb pain was unchanged. She did not have any pain in the medial forearm, but also didn't have much pain in the forearm prior to the injection on this date. Dr. Katz noted that Petitioner could continue regular work duties but must wear an elbow pad for ulnar neuritis.

On November 9, 2004, Dr. Mirkovic noted Petitioner's benefit from cervical injection and recommended another injection. He diagnosed foraminal stenosis with radiculopathy.

Claim Number 06 WC 6834

The Petitioner testified that on November 3, 2005, she sustained a fifth injury. She testified that she had been working on a case that contained 51 items in paper bags. She had to perform the same series of steps on these items as with all the other cases, which resulted in severe pain in her right hand, right thumb, right wrist, right elbow, right shoulder, and neck. She told her supervisor on that date that she needed medical treatment. Timely notice of this injury is not disputed.

On February 17, 2006, the Petitioner returned to Dr. Carroll and complained of pain in the right elbow. Dr. Carroll diagnosed right lateral epicondylitis, cervical radiculitis, and sprains and strains of the right wrist and right hand. He ordered a new thumb Spica splint and allowed Petitioner to continue full duty work. Dr. Carroll considered the conditions work-related. Petitioner began physical therapy at OccuSport which she performed for six weeks.

The Petitioner returned to Dr. Carroll on April 14, 2006 and he noted Petitioner complained of chronic pain in the right elbow and some discomfort in the right lateral epicondyle. She also still had neck and right shoulder complaints. Dr. Carroll diagnosed triceps tendonitis and lateral epicondylitis.

Dr. Carroll referred Petitioner to Dr. Mirkovic and kept her at full duty. Petitioner continued physical therapy.

The Petitioner returned to Dr. Carroll on June 12, 2006 and he noted that her neurologic examination confirmed some epicondylitis and ulnar neuritis. Dr. Carroll recommended the Petitioner continue working, consider seeing a physiatrist, and follow up with a spine surgeon.

On August 1, 2006, Petitioner saw Dr. Mirkovic, who noted neck pain, right scapular and shoulder pain, and right arm ache. He prescribed an MRI of the cervical spine, and an EMG/NCV study of the upper extremity.

Petitioner underwent a cervical spine MRI on August 4, 2006 which showed multilevel degenerative changes. An EMG/NCV study performed on August 4, 2006 was reported to be an abnormal study indicative of chronic, mild, right C5-7 cervical polyradiculopathy without evidence of ongoing denervation. There was no electrodiagnostic evidence of a right medial mononeuropathy at the wrist or ulnar mononeuropathy.

Petitioner sought treatment with Dr. Brian Couri of the Chicago Institute of Neurosurgery and Neuroresearch on August 14, 2006. Dr. Couri's assessment included; 1) right-sided snapping scapula secondary to scapular stabilizing muscle weakness which is very prominent with significant scapular dysfunction; 2) right medial and lateral epicondylitis most likely due to overuse from the scapular dysfunction; 3) positive Hawkins' sign on the right side with right-sided impingement syndrome which is probably secondary to the scapular dysfunction with rotator cuff overuse and the weakness of the rotator cuff muscles; 4) bilateral neck pain over bilateral C2-3, C3-4, and C4-5 cervical zygapophyseal joints with left-sided osteoarthritis and right C1-2 zygapophyseal joint dysfunction, probably more secondary to the muscle imbalances but could very well be due to discomediated pain causing some pain in the cervical spine and leading to the capsular dysfunction; 5) Right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis which very well could be causing the patient to have the cervical spine pain and the shoulder pain leading to the scapular dysfunction which is the main cause of all of the rest of the patient's current symptoms; 6) Right-sided thoracic outlet syndrome, more prominent than that on the left side, which is more than likely functional in nature as opposed to any true impingement upon the thoracic outlet. It is probably more functional due to the scapular stabilizing weakness. Dr. Couri prescribed physical therapy and allowed Petitioner to continue full duty work.

Petitioner continued physical therapy at OccuSport and followed up with Dr. Couri. On October 9, 2006, Dr. Couri's assessment was a right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis; 2) right-sided functional thoracic outlet syndrome; 3) what appears to be a right very mild C5 radiculitis/radiculopathy; 4) right scapular dysfunction with shoulder impingement secondary to the C5 radiculopathy. Dr. Couri recommended a right C5 transforaminal epidural steroid injection, which was performed on October 31, 2006.

On November 7, 2006, the Petitioner was involved in an unrelated motor vehicle accident. The Petitioner testified that she was hit while making a U-turn and suffered *left* upper trapezius muscle pain and *left-sided* neck pain, neither of which exacerbated the right-sided neck pain she was experiencing from her work injury. The Petitioner testified that there was no injury to her right upper extremity in this automobile accident.

On November 13, 2006, Petitioner attended physical therapy with OccuSport and the therapist noted that Petitioner's recent motor vehicle accident affected the left upper trapezius and had no effect on the work-related right side. It was noted that the Petitioner reported an overall improvement in her right-sided symptoms since her epidural injection on October 31, 2006. On November 14, 2006 Dr. Couri noted that the motor vehicle accident caused left scapular/shoulder-area spasms and increased left sided neck pain, but that her right-sided neck pain did not become any worse. He allowed Petitioner to continue working full duty.

Dr. Couri performed additional injections to the right C2-3, C5-6, and C6-7 zygapophyseal joints on December 19, 2006. Petitioner continued therapy.

On February 2, 2007, Petitioner saw Dr. Couri again and he recommended that Petitioner continue full time work but to do one-third less cases, and to instead spend that time doing something like teaching which she had done in the past. Dr. Couri ordered another EMG/NCV test of the right arm and an elbow injection.

An MRI arthrogram of the Petitioner's right shoulder was performed on June 14, 2007 at Future Diagnostics Group and was reported to be unremarkable.

The Petitioner was then referred by Dr. Couri to Dr. Giridhar Burra at Hinsdale Orthopedic Associates on June 22, 2017. Dr. Burra noted several positive physical exam findings relative to the right shoulder. Dr. Burra reviewed diagnostics and made a diagnosis of biceps tendinitis and a possible superior labrum anterior and posterior lesion. Dr. Burra recommended a diagnostic right shoulder arthroscopy.

On July 16, 2007, Petitioner returned to Dr. Couri who agreed with Dr. Burra's plan of diagnostic right shoulder arthroscopy. Dr. Couri stated that "it appears all of her symptoms came about with chronic repetitive work and lifting of heavy objects, and I believe that her right shoulder is the main cause of her symptoms which has exacerbated the neck and now the elbow." Dr. Couri placed Petitioner on 10 lbs. lifting restrictions and no overhead work.

On August 1, 2007, Petitioner was involved in another unrelated motor vehicle accident. She was taken to Silver Cross Hospital and complained of a left upper arm abrasion, a right shoulder abrasion, and mid lower back pain. The Petitioner testified that she only experienced slight soreness on her left side as a result of this accident.

On September 21, 2007, Dr. Burra authored a letter indicating that Petitioner's right shoulder/bicep symptoms preceded the motor vehicle accident and that she never had relief of symptoms prior to the motor vehicle accident. Accordingly, Dr. Burra opined that her shoulder symptoms were primarily related to her work injury and did not believe that the motor vehicle accident caused the injury.

On June 4, 2008, the Petitioner underwent right shoulder surgery at Silver Cross Hospital with Dr. Burra. The post-operative diagnosis was a SLAP lesion, subacromial bursitis and mild impingement in the right shoulder. The procedure consisted of right shoulder arthroscopy, SLAP lesion repair and subacromial decompression. Following surgery, Petitioner continued following up with Dr. Burra and performing physical therapy.

On November 19, 2008, the Petitioner reported to Dr. Burra that her right shoulder was doing well with increasing motion. However, she had a complaint on this date of rather extreme exacerbation of left elbow epicondylitis. She was diagnosed with left lateral epicondylitis. Dr. Burra recommended therapy for both the right shoulder and left elbow, and to remain restricted at work.

On January 7, 2009, Dr. Burra noted that Petitioner had made great progress with the right shoulder and could discontinue therapy and progress to a home exercise program. Dr. Burra placed Petitioner on restrictions for the right shoulder of no lifting greater than 25 lbs. and recheck in 6 weeks. Relative to the left elbow, Petitioner still complained of left elbow pain, worse with any gripping or lifting. Dr. Burra recommended a cortisone injection and continuation of physical therapy. The injection was done on this date. Dr. Burra also placed restrictions of no gripping with the left arm.

On April 17, 2009, Dr. Burra noted that Petitioner was pretty much asymptomatic for the right shoulder. He placed Petitioner at maximum medical improvement for her right shoulder and allowed her to return to full duty without restriction. However, for her continued right elbow symptoms, Dr. Burra noted that Petitioner had previous complaints suggestive of ulnar neuritis. He also noted that people with shoulder surgeries are at a higher risk because of the significant amount of flexion with performance of the rehab and immobilization after shoulder surgery, and this would put this condition for an exacerbation. He diagnosed ulnar nerve neuropathy and recommended a night splint. For the left elbow, Dr. Burra performed another injection and discussed possible surgical intervention if not improved. She was returned back to work with restrictions of no gripping with the left hand.

On June 25, 2009, the Petitioner saw Dr. Burra and reported that she was symptomatic in regard to her right elbow, complaining of paresthesia to the right ulnar nerve distribution. She was also tender over the left lateral epicondyle in the left elbow. Dr. Burra stated that "her right shoulder pathology [was] related causally to her right elbow symptoms..." For the left elbow lateral epicondylitis, he stated it is not a traumatic condition but an overuse syndrome. Dr. Burra discussed surgical options and recommended an MRI of the left elbow. A left elbow MRI was performed on July 9, 2009 at Future Diagnostics Group.

Dr. Burra reviewed the MRI of the left elbow on July 29, 2009 and diagnosed left epicondylitis. However, Petitioner reported improvement in her symptoms, and wanted to defer any surgical intervention unless symptoms worsen. Dr. Burra allowed her to continue to work with limitations of no repetitive gripping in the left hand, and to follow-up as needed.

On August 1, 2009, the Petitioner returned to Dr. Mirkovic for neck and right shoulder pain, and he ordered an MRI of the cervical spine and an EMG/NCV of the right upper extremity.

The Petitioner returned to Dr. Burra on December 2, 2009 complaining of increased right shoulder pain that freezes, cracks and pops, as well as increased pain with overhead activities or reaching behind or across her body. Dr. Burra diagnosed right elbow lateral epicondylitis as well as cubital tunnel syndrome. He recommended a repeat MRI arthrogram, and also to return after the EMG was done relative to the right elbow.

The Petitioner returned to Dr. Burra on January 6, 2010. Despite a negative EMG, Dr. Burra felt that the Petitioner had left elbow cubital tunnel syndrome and recommended ulnar nerve transposition surgery. For the right elbow, he diagnosed lateral epicondylitis, and recommended conservative treatment. Relative to the right shoulder, the MRI arthrogram showed some post-

surgical changes, but Dr. Burra recommended trying to manage it conservatively. The Petitioner was kept on restrictions of no repetitive gripping and no lifting greater than 5 lbs.

On July 2, 2010, the Petitioner had another EMG with Dr. Wayne Kelly of Health Benefits Pain Management. The EMG was noted to be abnormal, and the impression was 1) a right-sided chronic underlying chronic C6-7 cervical radiculopathy with evidence of primarily chronic axonal involvement; 2) a superimposed right-sided mild chronic compression/entrapment ulnar neuropathy across the elbow (Cubital tunnel syndrome) with evidence of mild focal demyelination and mild chronic axonal involvement, likely indicative of a double crush injury; 3) a bilateral moderate chronic compression/entrapment median mono neuropathies at the wrist (carpal tunnel syndrome) with evidence of moderate focal demyelination of both sensory and motor nerves as well as chronic axonal involvement; 4) no electrophysiological evidence of an underlying sensory/motor polyneuropathy or right brachial plexopathy. Dr. Kelly recommended two C6-7 cervical injections, a right ulnar nerve steroid block along the ulnar nerve, and a right distal medial nerve steroid block at the carpal tunnel and use of cock-up wrist splints.

Claim Number 10 WC 39044

The Petitioner testified that on August 2, 2010, she was injured for a sixth time when working on a case with several kilos of plant material wrapped in multiple layers of saran wrap. The Petitioner testified that she was using an X-acto knife to cut open the packages and enter the information into the computer. By the time she was done analyzing, sampling, and repackaging, her right and left hands, wrists, and thumbs were in significant pain.

The Petitioner reported the incident to her supervisor and an accident report was eventually completed. The Petitioner reported in the accident report that she was opening packaged kilos of cannabis. She had to cut open the package and remove the cannabis for weight and analysis. During these job duties, she felt pain in her right wrist, right elbow, left wrist, and bilateral hands. Timely notice of this injury is not disputed.

On August 16, 2010, the Petitioner returned to Dr. Burra, and she reported that her right shoulder pain was significantly resolved, and her left elbow pain was improved. She complained, however, that she was very limited and affected by her right elbow pain. She reported the recent work activity of opening multiple kilo packs which involved significant flexion/extension across her right elbow and had worsened her symptoms. Dr. Burra reviewed the EMG from July 2010. Dr. Burra indicated that Petitioner had a double crush condition. Dr. Burra recommended ulnar nerve transposition surgery.

Surgery was performed on September 28, 2010 to the right elbow. The pre-and-post operative diagnosis was ulnar nerve compression neuropathy of the right elbow. The procedure performed consisted of right-side ulnar nerve anterior transposition with a subcutaneous technique. Petitioner was placed on sedentary work/paperwork only duties.

Petitioner continued following-up with Dr. Couri in 2010 and did physical therapy for the post-operative right elbow.

On November 17, 2010, Dr. Burra recorded that Petitioner's numbness and tingling in her right 4th and 5th fingers was resolving post-surgery. Her left elbow was asymptomatic as of this date. Dr. Burra placed Petitioner on continued work restrictions.

On December 28, 2010, Dr. Burra noted that the Petitioner's right 4th and 5th finger symptoms had resolved. Her right elbow was doing much better. Noting that the Petitioner's right elbow, right shoulder, and left elbow symptoms were under control, Dr. Burra released her from his care. Dr. Bura indicated that the Petitioner was able to return to work relative to the right elbow, right shoulder and left elbow, but he noted that the Petitioner was still treating with Dr. Couri for carpal tunnel syndrome.

The Petitioner continued treatment with Dr. Couri in early 2011 for bilateral carpal tunnel syndrome. On January 10, 2011, she complained of bilateral hand symptoms which were improving. She still had a complaint of left elbow pain at this visit and she reported that her work aggravated both conditions. Dr. Couri kept Petitioner on work restrictions.

On March 25, 2011, Dr. Couri performed a left eblow lateral epicondyle injection, and instructed Petitioner to continue using a cock-up wrist splint. She was kept on work restrictions. On April 19, 2011, Dr. Couri recommended another cervical MRI, and kept Petitioner on work restrictions.

On May 23, 2011, Dr. Couri reviewed the April 26, 2011 MRI. Petitioner reported doing better with the left elbow pain since the injection. She was still having mild left lateral elbow pain and left sided neck pain. Dr. Couri recommended left C6 and C7 transforaminal epidural steroid injections and physical therapy, which Petitioner wanted to defer for the time being. She would instead try a home traction unit for one to two weeks first. She was kept on work restrictions. Dr. Couri performed an additional left elbow injection on August 2, 2011.

The Petitioner continued following up with Dr. Couri in 2012. By October 1, 2012, Dr. Couri noted that Petitioner had bilateral wrist pain and weakness. She reported numbness and tingling with fine motor activities, and also decreased grip. Dr. Couri's diagnoses was bilateral moderate carpal tunnel syndrome. He discussed bilateral percutaneous carpal tunnel release surgery in the future. She was kept on work restrictions.

On October 26, 2012, Petitioner underwent bilateral *percutaneous* carpal tunnel release surgeries with Dr. Couri.

She returned to Dr. Couri on December 6, 2012 who noted that the carpal tunnel releases had failed. He referred the Petitioner to Dr. John Fernandez at Midwest Orthopedics at Rush for another opinion.

The Petitioner saw Dr. Fernandez for the first time on January 9, 2013, and he diagnosed the Petitioner with bilateral carpal tunnel syndrome, bilateral thumb CMC joint osteoarthritis, and bilateral upper extremity pain. He recommended bilateral carpal tunnel release procedures.

On February 8, 2013, Petitioner underwent left wrist carpal tunnel release with Dr. John Fernandez. On February 25, 2013, Dr. Fernandez noted that Petitioner's paresthesias in the left hand had nearly completely resolved.

On April 12, 2013, Petitioner underwent right wrist carpal tunnel release surgery with Dr. Fernandez. Petitioner saw Dr. Fernandez on April 29, 2013, who noted improvement after right wrist surgery relative to numbness and tingling. Her main complaint on this day was pillar pain primarily worse on the right than left, worse with direct pressure of the palm and also worse with lifting activities. Dr. Fernandez noted that Petitioner could work with restrictions until June 1, 2013 at which time she would be at maximum medical improvement and able to return to full duty work.

The Petitioner testified that she lost one day of work for each carpal tunnel surgery and that the Respondent continued to accommodate her restrictions. She testified that she did less repetitive work and she participated in more teaching activities at work.

The Petitioner continued to work on restricted duty until May 31, 2013 when she voluntarily retired from her employment with the State of Illinois.

On May 27, 2015, the Petitioner returned to Dr. Fernandez with complaints of a bump/nodule on her left palm which was slightly tender to palpation and bothered her when performing gripping and working out activities. Relative to the right upper extremity, she complained of volar wrist pain. Her neurologic complaints from the median nerve distribution were completely resolved at this point. Dr. Fernandez performed a physical exam which noted a slight thickening of the surgical site along the left palm, and also a Dupuytren's nodule associated with the middle finger of the left palm. Relative to the right wrist, she had very minimal swelling along the volar aspect. She had full range of motion of the hand, wrist, and elbow. X-rays were performed which revealed ulnar positive variance by approximately 2mm. Dr. Fernandez' diagnoses were 1) left hand Dupuytren's disease, nodular phase; 2) bilateral upper extremity pain beginning while working as a chemist in 2012. Some medications were prescribed, and she was told to follow-up as needed.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

The Petitioner was examined at the request of her attorney by Dr. Samuel Chmell on October 15, 2015. Dr. Chmell's deposition testimony was admitted into the record as Petitioner's Exhibit 20. Dr. Chmell testified as to his understanding of the Petitioner's job duties and work history as well as her history of injuries and his examination findings. Dr. Chmell made the following seven diagnoses for the Petitioner: 1) bilateral carpal tunnel syndrome and multiple tendinitis, both wrists status post bilateral carpal tunnel releases times two; 2) right elbow cubital tunnel syndrome, status post ulnar nerve decompression and anterior transposition; 3) right shoulder SLAP lesion and impingement

syndrome, status post arthroscopy SLAP repair and subacromial decompression; 4) right shoulder snapping scapula syndrome; 5) bilateral elbow lateral and medial epicondylitis; 6) traumatic aggravation of degenerative disc disease in cervical spine with right upper extremity radiculopathy; and 7) right thoracic outlet syndrome.

Relative to causation, Dr. Chmell testified as to each of his seven diagnoses:

Relative to the bilateral carpal tunnel syndrome/multiple tendonitis hands and wrist, status post bilateral carpal tunnel release times two, Dr. Chmell testified that these conditions are causally related to Petitioner's work accidents of January 9, 1996, February 8, 2000, July 3, 2001, and August 2, 2010. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right cubital tunnel syndrome, status post ulnar nerve decompression and anterior decompression and interior transposition, Dr. Chmell testified that this condition was causally related to the July 3, 2001 and the August 2, 2010 work accidents. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right shoulder SLAP lesion and impingement syndrome status post arthroscopy, SLAP repair and subacromial decompression, Dr. Chmell testified that this condition was causally related to the work accident of November 25, 2003, which was aggravated on November 3, 2005. Dr. Chmell testified that this injury was a result of Petitioner's repetitive activities at work and that all treatment for those conditions to date has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right shoulder snapping scapular syndrome, Dr. Chmell testified that this condition is causally related to the November 25, 2003 work accident which was later aggravated during the November 3, 2005 work accident. Dr. Chmell testified that all treatment for this condition was reasonable, necessary, and causally related to the work accidents.

Relative to the diagnosis of bilateral elbow lateral and medial epicondylitis, Dr. Chmell testified that the right arm condition was causally related to the July 3, 2001 work accident and was further aggravated by the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell testified that the left elbow condition became involved after the August 2, 2010 work accident. Dr. Chmell opined that all treatment to date for these conditions has been reasonable, necessary, and related to the work accidents.

Relative to the diagnosis of cervical spinal traumatic aggravation of degenerative disc disease with right upper extremity radiculopathy, Dr. Chmell testified that this condition was causally related to the work accident of February 8, 2000, and further aggravated by the July 3, 2001, November 3, 2005, and August 2, 2010 work accidents. The condition was confirmed by positive EMG findings following the November 3, 2005 work accident. Dr. Chmell opined that all treatment to date for this condition has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right thoracic outlet syndrome, Dr. Chmell testified that this condition was causally related to the February 8, 2000 work accident, which was later aggravated during the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell opined that all

treatment for this condition to date has been reasonable, necessary, and related to the work accidents.

Dr. Chmell reviewed several accident reports which were included in Petitioner's Deposition Exhibit #4 at the deposition and noted that Petitioner's job duties as described in the reports are consistent with the type of activity that could cause the conditions he diagnosed.

Dr. Chmell opined that as of the date he saw Petitioner on October 15, 2015, Petitioner was at maximum medical improvement. Dr. Chmell also opined that Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma. Finally, Dr. Chmell testified that Petitioner's work restrictions in this case have been related to her work injuries.

Dr. Chmell testified that he disagreed with Dr. Verma's conclusion that the Petitioner's work was not consistent with a mechanism to cause A-C joint arthrosis or biceps tendon superior labral tearing. Dr. Chmell opined that repetitive motion activities can affect the shoulder when the labrum is stressed and eventually shreds and tears. Dr. Chmell further disagreed with Dr. Verma's conclusion that Petitioner reached MMI on March 17, 2008. Dr. Chmell disagreed because he believed Petitioner's shoulder surgery on June 4, 2008 helped her condition.

At the request of the Respondent, the Petitioner was examined by Dr. Nikhil Verma on March 17, 2008 and April 17, 2017 and he performed a record review on January 10, 2018. Dr. Verma's April 4, 2018 deposition testimony was admitted into the record as Respondent's Exhibit 20.

With regard to his examination of the Petitioner on March 17, 2008, Dr. Verma testified that he examined the Petitioner and reviewed the Petitioner's medical records from 2002 through 2007. Dr. Verma testified that he didn't review a written description of the Petitioner's job duties in preparation for the exam but the Petitioner described to him that her work as a forensic scientist involved using her hands for fine work, including opening small packages and testing substances and powders. Dr. Verma's diagnosis was right upper extremity pain with possible cervical spondylosis and radiculopathy. Dr. Verma did not believe this to be causally related to her job duties, because he did not locate a diagnosis within the shoulder that would be responsible for her symptoms, which he viewed to be diffuse in nature and not explained by the Petitioner's AC joint, biceps, or SLAP problems. Dr. Verma further testified that a repetitive use type mechanism is not consistent with a SLAP pathology in an individual of the Petitioner's age group.

Dr. Verma stated that degenerative changes in the labrum are common for patients in Petitioner's age group, and that the only repetitive use mechanism that generates SLAP tears is throwing a baseball at 80-plus miles per hour, which is not an activity in which he believed Petitioner was participating. Dr. Verma stated that repetitive work would be similarly inconsistent with superior labral pathology. Dr. Verma did not believe that the Petitioner's clinical exam findings supported the diagnosis of superior labral pathology, given their diffuse nature involving multiple components of her upper extremity.

Dr. Verma opined that Petitioner did not require any additional medical treatment for her shoulder related to a work injury, did not require any work restrictions, and was at maximum medical improvement.

With regard to his examination of the Petitioner on March 17, 2017, Dr. Verma testified that he reviewed the Petitioner's medical records from Dr. Burra, pain management records, records from Hinsdale Orthopedics, and records from Dr. Chmell. Dr. Verma noted that Petitioner's bilateral shoulders were normal aside from healed incisions on the right side and he indicated that the Petitioner demonstrated full range of motion, normal cervical motion, normal neurovascular systems, and no provocative testing findings on either shoulder. Dr. Verma opined that the Petitioner's right shoulder was essentially normal both objectively and subjectively. She had undergone right shoulder SLAP repair, which Dr. Verma did not believe was causally related to the work activities. Dr. Verma also opined that Petitioner was at maximum medical improvement for the shoulders, that no additional treatment was needed, and that she did not require any work restrictions relative to the shoulders.

With regard to his review of additional medical records of the Petitioner's treatment from 1996 through 2010, Dr. Verma testified that he also reviewed a job description in conjunction with authoring this report. Following his review of the updated records, Dr. Verma diagnosed the Petitioner with chronic upper extremity pain with possible fibromyalgia-type symptoms. Dr. Verma again stated that he did not believe Petitioner's condition to be causally related to her job duties.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

After reviewing all testimony and evidence, the Arbitrator hereby finds that the Petitioner did sustain accidents that arose out of and in the course of her employment by the Respondent on January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010. The accidents are supported by the Petitioner's testimony and corroborated by the accident reports and the treating medical records.

The respondent did not call any witnesses to dispute the Petitioner's version of her job duties or how the accidents occurred.

With regard to the issue of Notice, the Arbitrator notes that the Respondent only disputed the issue of timely notice with regard to the initial injury of January 9, 1996 (Claim Number 04 WC 13698). Based upon the Petitioner's unrebutted testimony, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Several of Petitioner's treating physicians provided opinions as to causation in this case over the years.

On March 27, 1996, while referring to Petitioner's soft tissue/tendons in the right forearm, Dr. Brannegan noted that "it sounds as if [Petitioner's] work demands a fair amount of repetitive fine hand movement, and this probably aggravates this problem."

Dr. Bayliss indicated in February and March of 2000 that Petitioner's symptoms are related to the ergonomics of her workstation and recommended altering the workstation.

Kurt James Keppner, D.C. noted on April 28, 2000 that Petitioner's condition has deteriorated over the last four months caused by her overuse at an ergonomically unsound workstation that places undue stress and strain on her neck and upper back.

On May 30, 2002, Dr. Shea at Loyola noted that "working aggravates all of her symptoms" while discussing Petitioner's neck, right arm, right thumb and grip strength.

On June 18, 2002, Dr. Bednar noted "I believe the work that she does aggravates her current condition." He also ordered her workstation be modified.

On February 6, 2004, Dr. Charles Carroll at Northwestern noted "[Petitioner] has an ongoing problem which has been further aggravated by her more recent work stress" while discussing a possible diagnosis of neuritis of the upper extremity. On February 26, 2004, Dr. Carroll stated, "I have considered her present condition of ill-being to be aggravated by the work that she discussed in previous correspondence."

Dr. Burra at Hinsdale Orthopedics stated on August 16, 2001 that "while the shoulder per se does not cause her ulnar nerve symptoms at the elbow... I have seen incidence or worsening of cubital tunnel syndrome following shoulder surgery because of the degree and duration of flexion that is required across the elbow both in the immediate postoperative period while she is in the sling as well as during the course of rehabilitative exercise and physical therapy following shoulder surgery, and I have seen this in my practice where there is an aggravation of this. As such, there is some relationship between her shoulder surgery and her elbow symptoms."

Dr. Burra also opined as to causation for the right shoulder SLAP lesion and biceps tendinitis in his September 21, 2007 correspondence. In this note, Dr. Burra opined that there is a clear-cut causal relationship of the work injury of November 3, 2005 to the right shoulder condition. He ruled out the auto accident as a cause of her condition.

Dr. Samuel Chmell, who examined the Petitioner at her attorney's request, testified that the sum of all the Petitioner's job duties involved repetitive stressful and difficult movements of Petitioner's upper extremities, right greater than left. He testified that the Petitioner did these tasks for 32 years, which was significant because her job duties subjected her upper extremities to repetitive motion activities, which is akin to overuse activities. Dr. Chmell testified that the Petitioner's job duties are consistent with the type of activity that could cause the conditions diagnosed in this case.

Dr. Chmell found seven diagnoses, which he opined were causally related to one or more of the work accidents in this case. Dr. Chmell noted that the Petitioner did not have any problems with her neck or upper extremities prior to working as a forensic chemist for the Respondent. Dr. Chmell

opined that the following seven diagnosed conditions were causally related to the Petitioner's work accidents:

1) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Nikhil Verma, the Respondent's examining physician, opined that Petitioner's diagnosis was chronic upper extremity pain with possible fibromyalgia-type symptoms. He did not feel that these conditions were causally related to her job duties. Dr. Verma only evaluated Petitioner relative to her bilateral shoulders and he did not evaluate her for any other body parts or conditions.

After reviewing all of the medical records, testimony and evidence, the Arbitrator finds the causation opinions of Petitioner's treating doctors to be consistent with the evidence and persuasive. The opinions and testimony of Dr. Samuel Chmell are credible and well-founded. Dr. Chmell's opinions correlate with those of Petitioner's treating doctors. Dr. Chmell also understood Petitioner's job duties consistent with Petitioner's testimony. While the Arbitrator notes the findings and opinions of Dr. Verma, the Arbitrator finds the causation opinions of the Petitioner's treating physicians, including Drs. Brannnegan, Carroll, Bayliss, Keppner, Shea, and Bednar to be persuasive. The Arbitrator also finds the opinions of Dr. Sam Chmell to be sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's work injuries on January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

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:

At trial, Petitioner submitted evidence of unpaid medical bills totaling $58,148.92, as summarized in Petitioner's Exhibit 31. Dr. Chmell testified that all medical treatment rendered to the Petitioner for her diagnosed conditions was reasonable, necessary, and causally related to the work accidents in this case. The Arbitrator hereby adopts the opinions of Dr. Chmell, which are sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof and finds that the unpaid medical bills totaling $58,148.92 set forth in Petitioner's Exhibit 31 are reasonable, necessary, and causally related to the work accidents of January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Additionally, the Petitioner submitted evidence of out-of-pocket travel/mileage costs as summarized in Petitioner's Exhibit 31. Section 8(a) of the Act states that the employer shall pay for treatment, vocational rehabilitation, and all services reasonably required to cure or relieve the effects

of the accidental injury. 820 ILCS 305(8)(a). Travel expenses are awarded in cases where it was reasonably necessary for the petitioner to travel in order to receive medical treatment. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). Here, the Petitioner's travel for treatment from 1996 through 2012 was for physical therapy, doctor's appointments, and testing, which all constitute reasonable travel expenses under the law. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate.

The Petitioner's mileage for travel to and from medical appointments as submitted in Petitioner's Exhibit 31 totals 17,629 miles. Applying the appropriate "IRS medical" rate applicable at the time of the travel, results in the total amount of $2,841.00 due. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate in the amount of $2,841.00.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she underwent surgery to her right shoulder on June 4, 2008 and that she was off work as a result of that surgery through July 29, 2008, a period of 8 weeks. The Petitioner testified that she underwent surgery to her right elbow on September 28, 2010 and that she was off work as a result of that surgery through October 2, 2010, a period of 5/7 weeks. The Petitioner underwent surgery to her left and right hands on February 8, 2013 and April 12, 2013, respectively, and that she was off work for one day after each of those surgeries, a period of 2/7 weeks. Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits for the periods of June 4, 2008 through July 29, 2008, a period of 8 weeks, September 28, 2010 through October 2, 2010, a period of 5/7 weeks, February 8, 2013, a period of 1/7 weeks, and April 12, 2013, a period of 1/7 weeks.

While the Petitioner claimed to be entitled to Temporary Partial Disability benefits for the hours of work that she missed obtaining treatment and therapy, the Arbitrator finds that the Petitioner failed to provide sufficient specific evidence of the actual periods of disability to allow the calculation of the exact amount of Temporary Partial Disability benefits that may be due, if any. The Arbitrator finds, therefore, that the Petitioner failed to meet its burden of proof with regard to what Temporary Partial Disability benefits, if any, are due. Accordingly, no Temporary Partial Disability benefits are awarded herein.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that Dr. Fernandez, the last physician who treated the Petitioner, noted that the Petitioner would be at maximum medical improvement by June 1, 2013 at which time she would be able to return to full duty work.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into

the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

Dr. Chmell, who examined the Petitioner at the request of her attorney on October 15, 2015, found seven diagnoses, which he opined were causally related to one or more of the Petitioner's work accidents:

2) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Chmell opined that the Petitioner was at maximum medical improvement. Dr. Chmell also opined that the Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a cumulative result of the Petitioner's six work injuries the Petitioner sustained permanent partial disability to her whole person to the extent of 27% thereof.

In Support of the Arbitrator's Decision relating to (N.), Is Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent claimed a credit under Section 8(j) of $17,894.58 (04WC13699); $3,955.04 (04WC13736); $33,044.57 (06WC6834). Respondent entered exhibits #13, 14, and 15 in support of their alleged 8(j) credit. Petitioner disputed the Respondent's entitlement to an 8(j) credit at the time of arbitration.

However, after the hearing on June 4, 2019, the parties entered into a stipulation on June 5, 2019 wherein they agreed that "the payments made by the Respondent referred to and contained in Respondent's exhibits 13, 14, and 15 were made by the workers' compensation claims department who administers, pays, and adjusts workers' compensation claims for the State of Illinois. The State

of Illinois is a self-insured employer under the Illinois Workers' Compensation Act. They are not payments made by a group insurance carrier."

The Arbitrator finds that the Respondent is entitled to credit for all of the 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC008617
Case Name	NEIL, BRUCE W v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0206
Number of Pages of Decision	10
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	LARRY MAYSTER
Respondent Attorney	Stephanie Lipman

DATE FILED: 4/21/2021

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

Bruce Neil,

Petitioner,

vs. NO: 14 WC 8617

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of Section 5(b) 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 10, 2019, is hereby affirmed and adopted.

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

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

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: **4/21/2021**

MP:yl
o 4/15/21
68

/s/ *Marc Parker*

/s/ *Barbara N. Flores*

/s/ *Christopher A. Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEIL, BRUCE W Case# **14WC008617**

Employee/Petitioner

CITY OF CHICAGO

Employer/Respondent

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

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

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

4712 LARRY S MAYSTER LTD
ANDREA MAYSTER
221 N LASALLE ST SUITE 2350
CHICAGO, IL 60601

0010 CITY OF CHICAGO LAW DEPT
MATTHEW LOCKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bruce W. Neil
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **8617**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **September 3, 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 $**41,667.60**; the average weekly wage was $**801.30**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**10,608.29** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**10,608.29**.

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

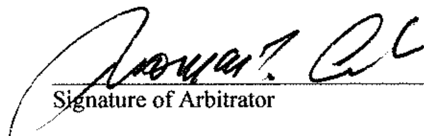
ORDER

Permanent partial disability

Based on the factors in 820 ILCS 305/8.1b and the record taken as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 10% of a leg (21.5 weeks at $480.78 per week) pursuant to 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

Date

SEP 10 2019

Bruce W. Neil v. City of Chicago, No. 14 WC 8617

Preface

The parties proceeded to hearing July 2, 2019, on a Request for Hearing indicating the following issues in dispute: whether Respondent is liable for unpaid medical bills; what is the nature and extent of the injury; and whether respondent is entitled to a credit in connection with a lien in a third party suit. Petitioner testified. No transcript was ordered.

Findings of fact

Bruce Neil (Petitioner) testified that on September 3, 2013, he was a parking enforcement agent with the Department of Finance for the City of Chicago (Respondent). While working in the 1400 block of Fillmore, he was struck by a car, sustaining a large wound to his right leg. He told his supervisor and an ambulance was called.

Records of the Chicago Fire Department indicate emergency services arrived at Fillmore and Loomis at 7:47 am, finding Petitioner had a six inch laceration to the right leg below the knee. He was taken to the University of Illinois Hospital. Petitioner's Exhibit B.

Petitioner testified he was seen at the emergency room and treated. The records of the University of Illinois Medical Center indicate Petitioner was seen in the emergency room September 3, 2013. He was hit by the license plate of a slow moving vehicle, resulting in a large superficial laceration of the right calf. Petitioner was diagnosed with a laceration of the lower extremity, given Norco, and advised to follow up with his family doctor. Suture repair was done and Petitioner was advised a skin graft might be necessary. Petitioner's Exhibit G.

Petitioner testified he treated with MercyWorks. The records of MercyWorks indicate Petitioner was seen September 4, 2013. Dr. Nagib Ali noted a large L-shaped laceration with 18 stitches in place. The wound was cleaned and redressed. Petitioner was kept off work. On September 16, 2013, sutures were removed, the wound was debrided and the wound was redressed. Petitioner was advised to see Dr. Lawrence Iteld. The records note Iteld called Dr. Homer Diadula, and informed him a skin graft would be needed and Petitioner should be hospitalized for five days. Petitioner's Exhibit C.

Petitioner testified he followed up with Geldner and Iteld. The records of the Geldner Center indicate Petitioner was seen as a referral from Dr. Homer Diadula on September 17, 2013. Dr. Iteld noted a fairly substantive area of flap necrosis on the back of Petitioner's leg. He noted Petitioner was an active smoker and discussed with him it was a significant risk factor for wound healing and skin graft not taking. Petitioner would be at a high risk for complications. Iteld recommended debridement and split thickness skin graft. On November 1, 2013, Petitioner again saw Iteld. Examination of the wound noted hypertrophic granulation tissue, with no good sign of healing. Iteld saw no other solution but a skin graft. Petitioner had not been applying Silvadene as directed. Petitioner indicated he wanted to see another doctor. Petitioner's Exhibit F. Petitioner's Exhibit F has, in the notes of September 17, 2013, a number of extraneous comments and highlights obviously not part of the medical records. Exhibits should never be

submitted in this manner. I have not considered those improper embellishments. The same is true for Petitioner's Exhibit L.

Petitioner testified he sought a second opinion at Saint Anthony's Hospital, and received a recommendation from Dr. Zappa. There are no records from Saint Anthony Hospital or Dr. Zappa that were introduced into evidence. Petitioner's testimony was less than clear regarding the remainder of his medical treatment. The lack of complete records (many are simply duplicates) complicates a comprehensive recitation of the medical facts in this case.

Petitioner's Exhibit A, identified in a handwritten list of exhibits as "U of I Med" has absolutely no identification of the entity providing the service or treatment. It is neither certified nor received in response to subpoena. Yet Respondent offered no objection to its introduction. So be it. The mystery provider indicates Petitioner was seen 44 times between November 12, 2013, and September 20, 2014, for office visits from removal of damaged skin and underlying tissue and debridement. Those records indicate referral from Dr. Zappa's office for treatment from Lawndale Health Center. Those records are replete with Petitioner's refusal to obtain Promogon for his wound or to have vascular studies that were long ordered. The records note the wound was not progressing and Petitioner refused to comply with instructions. There were many missed appointments. Petitioner refused to be treated three times a week, necessary to prevent infection. In August 2014, he suffered a new wound in a bike accident. Petitioner's Exhibit A.

Petitioner testified he submitted to an independent medical examination in January 2014 by Dr. Ostric. Dr. Srdjan Ostric, a certified plastic surgeon, examined Petitioner January 20, 2014. Ostric observed a small superficial open wound, clean without infection, without drainage or pain. Petitioner was walking normally. Ostric reviewed records from MercyWorks, Dr. Iteld, and Dr. Zappa's office. Ostric found Petitioner's right calf injury almost completely closed. It was related to the work accident. He found Petitioner's current treatment necessary and related to the accident. He recommended no further treatment, as the wound was essentially healed. He said Petitioner could return to full duty without restrictions, and was at MMI. Respondent's Exhibit 4.

Petitioner testified he returned to work January 20, 2014. Petitioner retired October 31, 2015.

Conclusions of Law

Disputed issue **J** is has Respondent paid all appropriate charges for all reasonable and necessary medical services. Petitioner claims unpaid medical bills of $1,774.72 to APM; $172.00 to Dr. Iteld and Geldner; $276.58 to Saint Anthony; $528.00 to Dr. Iteld.

APM, likely Advanced Physical Medicine, is supposedly for an EMG study March 2, 2015, two months after Petitioner was at MMI and returned to work. Dr. Aleksandr Goldvekht honestly noted ". . . it is in my best interest that the patient will have constant chronic pain in his right calf and longer healing time." The EMG was normal. There is no award made to APM, as they were seen after MMI, with no note of referral from any treating physician. There was no

previous complaint of neuropathy or lumbosacral radiculopathy. Petitioner's Exhibit E; Petitioner's Exhibit M; Petitioner's Exhibit N.

The Geldner Center and Dr. Iteld, as can be gleaned by Petitioner's Exhibit K, related to treatment subsequent to Petitioner's being at MMI and returning to work. Neither is awarded.

Charges of $276.58 to Saint Anthony contained in Petitioner's Exhibit I are for services performed almost a year after Petitioner was placed at MMI and returned to work. They are unaccompanied by any medical records to any service or treatment. No payment is awarded.

Disputed issue **L** is, what is the nature and extent of the injury. I find as a conclusion of law, Petitioner sustained a right calf injury, open wound that became necrotic and was treated by debridement. Petitioner rejected a skin graft to his lower leg. Here permanent partial disability is established using the criteria found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, this Arbitrator finds as follows.

With regard to subsection (i) of Section 8.1b(b), this Arbitrator notes no permanent partial disability impairment report and/or opinion was submitted into evidence. Because of this, I give this factor no weight in determining the level of disability.

Regarding subsection (ii) of Section 8.1b(b), the occupation of the employee, I note Petitioner went back to work for the Department of Finance writing tickets for illegally parked cars, with no restrictions and worked for nine months before he retired. I give this factor no weight in determining the level of disability.

Regarding subsection (iii) of Section 8.1b(b), this Arbitrator notes Petitioner was 59 years old at the time of the accident. I give this factor some weight in determining the level of disability.

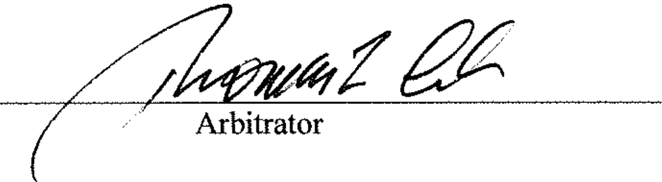
With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings. There is no evidence Petitioner's future earnings capacity was adversely affected by the accident. Petitioner said he missed a step raise during the injury, but what that was and what it meant were never clarified. I give this factor no weight in determining the level of disability.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, I note Dr. Iteld's observations of June 3, 2014. Although post MMI, given Iteld's prior treatment of Petitioner, they are valuable. He notes Petitioner has a permanent scar, sensitive to the elements, touch and changes in temperature. The scar, he says will remain fragile and have a propensity to re-open. There also has to be consideration of Petitioner's continued smoking, for which he was warned would have an adverse effect on wound healing, as well as Petitioner's refusal to have vascular studies. I give this factor some weight in determining the level of disability.

Based on the above factors and the record taken as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 10% of a leg (21.5 weeks), pursuant to Section 8(e).

Disputed issue **N** is whether Respondent is due any credit.

Petitioner sued the person who struck him, lacerating his right calf. That case settled for $47,500.00. The Act requires the employer to pay an employee the amount of compensation paid under the Act. 820 ILCS 15(b). The parties settled that lien. The lien of $27,444.22 was paid in its entirety, less Attorney's fees and cost reductions. The Respondent received $19,296.29 in settlement of its lien. Respondent's Exhibit 1; Respondent's Exhibit 3. Respondent claims this as a credit. That is not a credit, it is a statutory right to reimbursement of compensation from a third party in the event of a judgement or settlement that is specifically set forth in the Act.



Arbitrator

9-9-19

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC004767
Case Name	SLAUGHTER, CRYSTAL B v. NORTHERN ILLINOIS UNIVERSITY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0207
Number of Pages of Decision	18
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	David Menchetti
Respondent Attorney	Alyssa Silvestri

DATE FILED: 4/21/2021

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 DU PAGE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Crystal Slaughter,

Petitioner,

vs. No. 16 WC 4767

Northern Illinois University,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a 49-year-old office assistant, testified that after leaving a meeting at work on January 26, 2016, she fell halfway down a staircase she had been descending. She landed on her left side, injuring her left knee, left elbow, left hip and abdomen. She was treated that day in the emergency room of Kishwaukee Hospital, where she was diagnosed with contusions of her abdomen, elbow, and knee. Petitioner was discharged after being given a knee immobilizer and crutches.

The day after her accident, Petitioner was seen at the Center for Family Health. She was prescribed medication and physical therapy for complaints of pain and swelling to her left knee. On February 3, 2016, Petitioner was seen for complaints of pain to her neck, shoulders, left wrist, and low back. She underwent MRI's of her neck, back and left knee; and received injections to her lumbar spine. Her diagnostic films revealed bulges and protrusions in her cervical, thoracic

and lumbar spines, and a herniated L4-5 disc. Petitioner's back pain became worse after she attended physical therapy for her legs at Midwest Orthopedics.

On March 16, 2016, physician's assistant Erlenbusch reported Petitioner's left knee pain was due to her herniated L4-5 disc, and recommended that Petitioner's physical therapy be geared more toward her lumbar spine. On March 21, 2016, Dr. Faubel also diagnosed an L4-5 disc herniation with radiculopathy, facet arthropathy at 3 levels, and left lower extremity weakness, and recommended bilateral lumbar epidural steroid injections. Dr. Shukairy concurred with Dr. Faubel's recommendation for lumbar epidural steroid injections.

Petitioner was authorized off work by Dr. Shukairy, Dr. Faubel, and her primary caregiver, NP Rasmussen. On March 29, 2017, Petitioner informed NP Rasmussen that her orthopedic physician had released her, and on that date, NP Rasmussen found that Petitioner was no longer disabled.

At arbitration, Petitioner testified that she currently had difficulty sleeping because of her pain. When she walks, her toes become numb quickly. Her skin hurts and feels like it's on fire. She has constant back pain which shoots into her legs. She has to wear a neck brace when she watches television. Petitioner now requires a personal assistant to help her with laundry, cooking and occasionally bathing. Petitioner still takes Gabapentin, Doxepin, cyclobenzaprine and 800 mg ibuprofen for her injuries.

The Arbitrator found some of Petitioner's conditions of ill-being to be casually related to her work accident, but only from January 27, 2016 through April 23, 2016. The Arbitrator found Petitioner failed to prove her cervical and lumbar spine conditions were causally related to her work accident, because Dr. Faubel could not find a clear cause of Petitioner's cervical or lumbar pain, and Dr. Shukairy noted that Petitioner's left-sided symptoms did not correlate with her right-sided L4-5 disc protrusion. The Arbitrator awarded Petitioner 12-4/7 weeks of TTD through April 23, 2016; $11,560.22 in medical expenses incurred through that date, and 5% person as a whole under §8(d)2.

The Commission views the evidence differently than the Arbitrator, and finds that in addition to the injuries the Arbitrator found causally related, Petitioner also proved her cervical spine and lumbar spine injuries were causally related to her accident. With regard to her left leg injuries, Petitioner required crutches, medication and physical therapy. Physician's assistant Erlenbusch opined that Petitioner's left knee pain was due to her herniated disc at L4-5. On May 23, 2016, Dr. Faubel confirmed the diagnosis of an L4-5 disc herniation, also noting that it did correlate with her pain and weakness, especially in the lower left leg. He recommended transforaminal epidural steroid injections, and continued Petitioner's off work status.

Although Petitioner's lumbar and cervical symptoms were not documented until a week after her accident, those conditions were likely initially overshadowed by her more painful injuries to her left elbow and left knee. Beginning February 3, 2016, Petitioner's lumbar and cervical

complaints were consistently documented in her medical records. Petitioner's April 27, 2016 cervical MRI revealed bulges protrusions, stenosis, and osteophytes at C5-6, causing moderate right-sided stenosis and impingement. No evidence was presented to show Petitioner had a subsequent or intervening accident or injury.

In his records, Dr. Alghafeer reported multiple times that Petitioner had a, "work-related injury resulting in chronic neck and low back pain." Petitioner's primary treater, NP Rasmussen, also reported that Petitioner's cervical and lumbar problems were caused by her January 26, 2016 work accident. In her report dated March 22, 2017, NP Rasmussen documented Petitioner's diagnosis as, "Work related chronic neck back injury." Respondent offered no medical opinion that Petitioner's spine conditions were not related to her work accident. The Commission finds the reports of Dr. Alghafeer and NP Rasmussen established Petitioner's cervical and lumbar spine conditions are causally related to her January 26, 2016 work accident.

Petitioner testified that prior to her accident, she was very active and in good health, and Respondent presented no evidence to refute that. Since Petitioner's work accident, she has been in constant pain, has difficulty with daily activities, and requires a personal assistant. The Commission finds Petitioner's injuries including her spine conditions, were causally related to her work accident through March 29, 2017, the date Petitioner's primary caregiver, NP Rasmussen, found her to be no longer disabled.

In determining the level of Petitioner's permanent partial disability, the Commission assigns the following weights to the five factors enumerated in §8.1b(b):

(i) Disability impairment rating: *no weight,* because neither party submitted an impairment rating.

(ii) Employee's occupation: *some weight,* because Petitioner's occupation as an office support specialist was mostly sedentary.

(iii) Employee's age of 49: *some weight,* because Petitioner had many years left of her work life expectancy.

(iv) Future earning capacity: *no weight*, because no evidence was presented to show Petitioner had a diminished earning capacity.

(v) Evidence of disability corroborated by the treating records: *significant weight,* because Petitioner was found to have, in her left knee, a hematoma, severe patellar chondromalacia, borderline patella alta, and trace effusion, which was painful and required physical therapy. In her lumbar spine, Petitioner suffered an L4-5 disc herniation with radiculopathy and facet arthropathy at 3 levels, which required lumbar epidural injections, physical therapy and medications. Petitioner's cervical spine MRI revealed bulges, protrusions, stenosis, and osteophytes at C5-6 causing moderate right-sided impingement.

The Commission therefore finds that Petitioner is entitled to 7.5% loss of use of her left leg, 7.5% person as a whole for her cervical spine injuries, and 7.5% person as a whole for her lumbar spine injuries.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and Respondent shall pay Petitioner temporary total disability benefits of $272.87 per week for 61-1/7 weeks, for the period of January 27, 2016 through March 29, 2017, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the outstanding reasonable and necessary medical expenses incurred in treating her injuries between January 26, 2016 and March 29, 2017, as provided by §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $253.00 per week for a total period of 91.125 weeks, for the reason that: Petitioner's left knee injury caused the 7.5% loss of use of the left leg as provided in §8(e)12 of the Act (16.125 weeks); her cervical spine injuries caused the 7.5% disability to the person as a whole as provided in §8(d)2 of the Act (37.5 weeks), and her lumbar spine injuries caused the 7.5% disability to the person as a whole as provided in §8(d)2 of the Act (37.5 weeks).

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: **4/21/2021**

/s/ *Marc Parker*

o-03/04/2021
MP/mcp
68

/s/ *Deborah L. Simpson*

/s/ *Barbara N. Flores*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0207

SLAUGHTER, CRYSTAL B
Employee/Petitioner

Case# **16WC004767**

NORTHERN ILLINOIS UNIVERSITY
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:

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

6153 ASSISTANT ATTORMNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

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

MAY 21 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Crystal B. Slaughter
Employee/Petitioner

Case # **16** WC **4767**

v.

Northern Illinois University
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **Wheaton/Elgin**, on **July 10, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ 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 26, 2016,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,283.67**; the average weekly wage was **$409.30**.

On the date of accident, Petitioner was **49** years of age, ***married*** with *?* 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, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.**

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

ORDER

Medical Benefits

$11,560.22 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 by respondent.

Temporary Total Disability

Respondent shall pay Temporary total disability benefits from **January 27, 2016** through **April 23, 2016**, or **12-4/7 weeks** at the rate of **$272.87 per week**.

Permanent Disability

Petitioner is entitled to **25** weeks, at **$253.00** per week, as petitioner's permanent disability has resulted in **5% person as a whole §8 (d) 2.**

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

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

Signature of Arbitrator

May 20, 2019

Date

MAY 21 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Crystal B. Slaughter	)
Petitioner,	)
vs.	**) No. 16 WC 4767**
Northern Illinois University	)
Respondent.	)
	)

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

This matter proceeded to hearing in Wheaton/Elgin on July 6, 2018. The parties agree that on January 26, 2016, 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 $21,283.67 in the year predating the accident and that her average weekly wage, calculated pursuant to §10, was $409.30.

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.

STATEMENT OF FACTS

On January 26, 2016, petitioner was employed by respondent as an office support specialist. Her office was in the Center for Black Studies. Her job duties included opening the building where she worked, setting schedules, registering students, assisting the professionals, setting up class rosters and purchasing. About once a week she had to walk to another building on campus.

On January 26, 2016, she had to walk to the office in the of the new chief diversity officer, Dr. Bernice Walden, to attend a meeting at 9 A.M. The building was located in the Altgeld building. Initially, she testified she did not recall the reason for the meeting. The meeting lasted about an hour. At the end, petitioner reminded Dr. Walden about a webinar. Dr. Walden asked petitioner to go set up her office for the webinar.

Petitioner testified, without rebuttal, that in one hand she had papers related to their meeting and the webinar; in the other hand she had her cell phone. As she descended the stairs, she was trying to contact a student in her office on her personal cell phone to set up the "smart class" webinar. Petitioner testified she was hurried. She made it to the first landing. As she took the first step after the landing, she fell down the stairs and woke up at the bottom of the stairs. She

described the shape of the stairs as "funny". The stairway curves. It was wider on the right. She confirmed the folders were in her left hand and her phone was in her right hand. A male person came to her aid. He found the papers under the staircase.

She had pain in her legs, clavicle and elbows immediately after the fall. She was taken via ambulance to Kishwaukee Hospital. She was instructed to see her own primary care physician (PCP) at the Center for Family Health. She was referred for physical therapy by her PCP and referred to Dr. Faubel at Midwest Ortho Institute. The last time she had seen a doctor at Midwest Ortho Institute was a couple of months before the hearing.

She received MRIs to her back, neck and knee. She received injections to her left hand and back. She had EMGs. She saw a rheumatologist, who ran tests and prescribed medication.

It takes her a while to get going in the morning. Her toes go numb. She has a personal assistant, who provides assistance for various tasks, including bathing.

Her skin hurts a lot; it feels like it burns. She has constant pain in the back that shoots down her legs. Her left arm practically numb. She always needs support. She testified that flying is difficult. When she coughs she has pain. Air causes pain. It feels like someone is pushing on her neck. She has to drink out of a paper cup as she can't lift a mug. She testifies it is difficult to reach for anything. She can't do anything.

On cross-examination she agreed the meeting was concerning her performance and regarding an issue with her immediate supervisor, Jay Coates, in that she sent confidential information to Dorothy Tillman. She said she was "attacked" at the meeting. The folders she had in her hand were regarding the disciplinary issues.

She denied she told the hospital she caught her shoe on the step. She did not know if the stairs were defective. She did not see anything on the stairs.

She confirmed she gave a statement to respondent's police.

She did not tell Dr. Rasmussen on January 27, 2016 or February 10, 2016 that she fell down at home.

She agreed she had fallen down in her garage about a year before the hearing; the exact date was unknown. She only remembered it was warm outside.

She agreed it was not until March, 2016 that she began noticing back pain; this was after she began physical therapy.

She testified her insurance limited her to a certain number of physical therapy visits.

She was discharged from Dr. Faubel when she failed to show up.

Although she filed for disability through SURS, on March 29, 2017, NP Debra Rasmussen refused to complete the disability form as she told petitioner she was no longer disabled. NP Rasmussen refused to complete the disability papers.

Petitioner has not contacted respondent about returning to work, even though on January 9, 2018 the PCP said she could.

She was taken off all medication by NP Debra Rasmussen.

She confirmed her daughter drove her to the hearing. She agreed she has flown to California.

Kishwaukee Hospital Records (PX.1)

Petitioner was treated in the emergency room after falling half way down 12 steps. She complained her left knee was banged up and hurt; she had left lateral abdominal pain and later said her elbow hurt. In the emergency room, X-rays were taken of petitioner's knee, a CAT scan was done to rule out internal injuries and later a (left) elbow X-ray.

She had a history of bronchitis and chronic shoulder pain.

According to the history taken by RN Kemph, petitioner stated; "I must have caught my shoe on a step." She denies dizziness or shortness of breath. She denied head or neck pain or injury. She had complaints of left knee, left hip, left lateral abdomen, left ribs, left elbow. The diagnosis was abdominal, elbow and knee contusions.

She was put on restricted work until she was cleared by the orthopedic surgeon.

The February 17, 2016 X-rays of both shoulders were negative for fracture or dislocations.

The CT scan of the cervical spine showed no post traumatic changes; only degenerative disc disease. The March 4, 2016 CT scan of the right arm showed no traumatic injury to the shoulder.

Midwest Orthopaedic Institute Records and Bills (PX.2)

Petitioner was seen by PA Amy Erlenbusch on January 27, 2016. She had complaints of left thigh and knee pain. Petitioner reported she could not move due to significant pain. Petitioner had a hematoma on her thigh and knee. She was kept off work.

She was seen on February 3, 2016 with the same complaints, plus some back pain. MRIs were ordered to insure there were no fractures. She was kept off work.

The February 5, 2016 left knee MRI showed chondromalacia; no fractures or meniscus injury were found.

She returned to PA Erlenbusch on February 10, 2016. The diagnosis was left knee and distal lateral thigh hematoma with chondromalacia of the patella. Physical therapy was ordered to get petitioner moving.

She was seen again on March 2, 2016 by PA Erlenbusch. She had been to physical therapy only once or twice. She was still using crutches. She was having problem flexing. The thigh hematoma had almost resolved. Because of the traumatic fall, a lumbar MRI was ordered. She was kept off work.

The March 10, 2016 lumbar MRI showed a disc bulge with broad-based left paracentral lateral extrusion, with no neural compression at L4-5, and minimal bulges at L5-S1 and L3-L4.

On March 16, 2016, PA Erlenbusch reported petitioner's left knee pain was due to herniated discs at the L4-5 and L5-S1 levels. Petitioner reported she was seeing her primary care doctor for her right shoulder and neck; a CAT scan was done. She was referred to the Spine Center for injections; physical therapy and Medrol Dosepak were prescribed. She was kept off work.

Petitioner was seen by Dr. Christopher Faubel on March 21, 2016. Petitioner now reports she fell down 20 to 30 stairs. Dr. Faubel diagnosed disc herniation at L4-5 with radiculopathy and weakness. Petitioner was scheduled for a L4 transforaminal epidural steroid injection. She was kept off work. She was seen again by Dr. Faubel on April 4, 2016 who continued to recommend the injection, and also ordered a spine surgical consult. She was kept off work.

Petitioner was seen by Dr. Mohammed Shukairy, as referral from Dr. Faubel, on April 23, 2016. Dr. Shukairy indicated petitioner's L4-L5 disc protrusion was on the right and did not correlate with petitioner's symptoms on the left. The exam was normal except for some weakness in the left hand. Because of the cervical complaints and ulnar neuropathy on the left, Dr. Shukairy recommended a cervical MRI and EMG of the upper extremities. Dr. Shukairy did not recommend surgery; however, he believed petitioner was a candidate for epidural steroid injection.

The April 27, 2016 cervical MRI showed a disc protrusion at C2-3 with mild stenosis, disc bulge and disc extrusion at C4-5, osteophyte at C5-6 with impingement of the C-6 nerve root, and

osteophyte at C6-7 with impingement of the C-7 nerve root and minimal central disc protrusion at C7-T1 causing no impingement.

Petitioner's April 29, 2016 EMG/NCV, performed by Dr. Faubel, was normal.

Petitioner returned to Dr. Shukairy on May 14, 2016. He did not recommend cervical surgery; stating petitioner should be managed with injections and physical therapy. Dr. Shukairy also ordered a thoracic MRI. She was referred back to Dr. Faubel and kept her off work until she was seen by Dr. Faubel.

The May 19, 2016 thoracic MRI showed disc bulges at T4-5, T5-6 and T6-7 without impingement; small left paracentral dis protrusions at T7-8, T8-9, and T9-10 without impingement.

Petitioner was seen by Dr. Faubel on May 23, 2016; the injections where scheduled and petitioner was kept off work.

Dr. Faubel performed a bilateral L4 transforaminal epidural steroid injection on May 27, 2016. She was kept off work.

On June 13, 2016, petitioner did not show or call to cancel or reschedule her appointment for the injection procedure. However, petitioner underwent another injection on June 15, 2016.

The June 28, 2016 EMG of the lower extremities showed bilateral S1 radiculopathy.

Petitioner returned to Dr. Faubel on July 13, 2016; physical therapy to cervical and lumbar spine was prescribed. She was seen for the initial physical therapy evaluation on July 20, 2016.

Petitioner was evaluated by Dr. Ibrahim Alghafeer on August 9, 2016 for rheumatoid arthritis. Dr. Alghafeer did not find petitioner had rheumatoid arthritis.

Petitioner returned to Dr. Faubel on August 17, 2016. She was to continue with physical therapy and kept off work. She was also referred to Dr. Kenny for an evaluation of her carpal tunnel syndrome.

Petitioner saw Dr. Kenny on August 19, 2016. Dr. Kenny's diagnosis was mild left carpal tunnel syndrome; petitioner received an injection into the carpal tunnel. She returned on to Dr. Kenny on September 13, 2016. Dr. Kenny questioned whether petitioner had carpal tunnel syndrome and recommended non-operative treatment. Dr. Kenny thought petitioner may have RSD and referred petitioner to physical therapy. Petitioner was initially evaluated on September 14, 2016 for carpal tunnel syndrome physical therapy. Petitioner returned to Dr. Kenny on November 9, 2016. Dr. Kenny thought petitioner may need further evaluation of possible fibromyalgia and referred her to Dr. Alghafeer for same.

On December 6, 2016, petitioner was discharged from physical therapy due to excessive cancellations and no-shows.

Petitioner was re-evaluated by Dr. Alghafeer on January 13, 2017. He again did not find evidence of rheumatoid arthritis.

Petitioner returned to Dr. Faubel on February 14, 2017, requesting a shower chair and walker. Her exam was basically normal. Dr. Faubel could not find a clear cause of petitioner's cervical or lumbar pain. At petitioner's request, Dr. Faubel ordered a functional capacity lift test.

Petitioner was seen once again by Dr. Alghafeer on April 20, 2017; Dr. Alghafeer came to the same conclusion; petitioner did not have rheumatoid arthritis.

The medical bills included with the records are:

$125.00 PA Erlenbusch (01/27/16)

$124.00 X-rays (01/27/16)

$125.00 PA Erlenbusch (02/03/16)

$2,734.00 Left knee MRI (02/05/2016)

$125.00 PA Erlenbusch (02/10/16)

$800.00 PT Evaluation (02/23/16)
$228.00 PT (02/26/16)
$152.00 PT (03/02/16)
$228.00 PT (03/09/16)
$3,655.08 MRI Lumbar Spine (03/10/16)
$228.00 PT (03/14/3016)
$67.00 PT (03/14/16)
$160.00 PT (03/17/16)
$152.00 PT (03/17/16)
$90.00 PA Erlenbusch (03/16/16)
$228.00 PT (03/23/16)
$269.00 Dr. Faubel (03/31/16)
$228.00 PT (03/28/16)
$67.00 Elec. Stim (03/28/16)
$184.00 Dr. Faubel (04/04/16)
$367.00 Dr. Shukairy (04/23/16)
$2,639.00 Cervical MRI (04/27/16)
$2,387.00 EMG/NCV Upper Extremities (04/29/16)
$125.00 Dr. Shukairy (05/14/16)
$2,800.00 Thoracic MRI (05/19/16)
$184.00 Dr. Faubel (05/23/16)
$2,754.00 Dr. Faubel-Lumbar ESI (05/27/16)
$2,754.00 Dr. Faubel-Lumbar ESI (06/15/16)
$2,154.00 EMG/NCV Lower Extremities (06/28/16)
$184.00 Dr. Faubel (07/13/16)
$800.00 PT Evaluation (07/20/16)
$304.00 PT (07/27/16)
$228.00 PT (07/29/16)
$228.00 PT (08/03/16)
$395.00 Dr. Alghafeer (08/09/16)
$228.00 PT (08/12/16)
$198.00 Dr. Faubel (08/17/16)
$538.00 Dr. Kenny (08/19/16)
$304.00 PT (08/16/16)
$228.00 PT (08/18/16)
$20.00 Foam Rolls (08/29/16)
$228.00 PT (08/22/16)
$228.00 PT (08/29/16)
$135.00 Dr. Kenny (09/13/16)
$293.00 Hand X-rays (09/13/16)
$860.00 Occupational PT Evaluation (09/14/16)
$228.00 PT (09/19/16)
$228.00 PT (09/21/16)
$30.00 No show (10/03/16)
$228.00 PT (10/20/16)
$228.00 PT (11/01/16)

$135.00 Dr. Kenny (11/09/16)
$228.00 PT (11/08/16)
$304.00 PT (11/08/16)
$228.00 PT (11/10/16)
$228.00 PT (11/14/16)
$228.00 PT (11/22/16)
$30.00 No show (11/28/16)
$198.00 Dr. Faubel (04/10/17)

Center for Family Health Records and Bills (PX.3)

Petitioner was seen by FNP Debra Rasmussen on January 27, 2016 in follow up to the ER visit for musculoskeletal pain. Petitioner was crying in pain with knee immobilizer in place, using crutches, mild swelling to left knee, screams in pain with light touch to knee. She was referred to Midwest Orthopaedic Institute.

Petitioner returned on February 2, 2016 with complaints of right shoulder pain. X-rays were ordered.

Petitioner returned on February 24, 2016. The right shoulder X-rays were normal. She complained of pain in both shoulders; worse on the right. She had complaints of right thumb pain and was tearful. A CT scan of petitioner's shoulder and cervical spine were ordered; she was referred to the orthopaedic surgeon.

Petitioner returned on March 23, 2016 for cervicalgia, pain in left shoulder and left knee, as well as back pain.

Petitioner was seen on May 25, 2016 to have disability paperwork completed. The diagnosis was cervicalgia and lumbago.

Petitioner was seen on September 7, 2016 for lab tests results and for disability paperwork for parking. She was seen again on September 15, 2016 for disability paperwork.

On January 25, 2017, petitioner presented to the clinic for paperwork as she was moving to California and needed the paperwork completed for housing.

Petitioner was seen on March 29, 2017 for paperwork and chronic conditions. Petitioner was advised by FNP Debra Rasmussen that her condition seemed to warrant her working as a specialist recommended she keep in motion. The SURS disability form dated March 29, 2017, indicated petitioner was no longer disabled.

The bills included with the records are:
$612.07 NP Rasmussen (01/27/16)
$612.07 NP Rasmussen (02/10/16)
$616.07 NP Rasmussen (02/24/16)
$256.07 NP Rasmussen (03/23/16)
$616.07 NP Rasmussen (04/13/16)
$616.07 NP Rasmussen (05/04/16)
$616.07 NP Rasmussen (05/25/16)
$661.07 NP Rasmussen (06/01/16)
$616.07 NP Rasmussen (09/07/16)
$616.07 NP Rasmussen (09/15/16)
$616.07 NP Rasmussen (10/19/16)
$617.62 NP Rasmussen (01/12/17)
$617.62 NP Rasmussen (01/25/17)

$257.62 NP Rasmussen (03/29/17)

Midwest Orthopaedic & Neurosurgical Specialist Records and Bills (PX.4)

Petitioner was seen by Dr. Kenny on December 20, 2017 and received an injection into the left carpal tunnel.

Petitioner was seen again by Dr. Alghafeer on January 9, 2018 with the same complaints. No further treatment was recommended. She reported her PCP no longer would prescribe pain medication so she is taking pain meds she received from friends.

Petitioner was seen by Dr. Kenny again on January 17, 2018 with the same complaints. No further treatment was recommended.

Petitioner was seen by Dr. Alghafeer on April 20, 2018 for chronic pain with no evidence of rheumatoid arthritis. She reported she had a personal assistant. She wanted Dr. Alghafeer to complete paperwork for her disability lawyer. Dr. Alghafeer recommended she return to the Spine Center.

The medical bills included with the records are:
$88.00 Dr. Kenny-Wrist (12/08/17)
$30.00 No show (12/11/17)
$495.00 Dr. Kenny – Wrist Injection (12/20/17)
$270.00 Dr. Alghafeer (01/09/18)
$155.00 Dr. Kenny (01/17/18)
$220.00 Dr. Alghafeer (04/20/2018)

Photos of Staircase (PX.5)

Petitioner identified the photos of those of the staircase where she fell.

Payment List (RX.1)

Respondent paid a total of $3,934.52 in medical expenses.

Wages Statement (RX.2)

According to the wage statement, petitioner earned $21,283.67 in the year pre-dating the accident and her average weekly wage was $409.30

Employer's First Report of Injury (RX.4)

The first report of injury was called in by petitioner's attorney on February 12, 2016. The report indicates petitioner slipped and fell down stairs and injured just about every part of her body due to this fall.

CONCLUSIONS OF LAW

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

The Arbitrator found petitioner to be overly dramatic in her mannerisms and responses. She responded to the questions on cross-examination with an indignant tone. Her physical complaints and presentation were bizarre and not correlated with the any complaints or findings contained in the medical records. Based upon the foregoing, the Arbitrator had difficulty with petitioner's credibility.

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

There is no dispute petitioner was in the course of her employment at the time of her fall down the staircase. The issue is whether petitioner's fall was the result of an accident that arose out of her employment with respondent.

Petitioner testified, without rebuttal, that she was carrying work papers in one hand and her cell phone in the other and that she was using her personal cell phone to contact a student to get a webinar set up for respondent's director as she descended the staircase. She also testified, without rebuttal, that she was in a hurry as the webinar was to start at 10:30 A.M. and it was after 10 A.M. when she had left the meeting with her director. According to the photos (PX.5) the stairway is curved; with the left being narrower than the right side. Petitioner reportedly fell down about twelve stairs.

Based upon the foregoing factors, and in accordance with the holding in *Knox County YMCA v. Il. Industrial Comm'n.*, 311 Ill. App. 3d. 880,725 N.E.2d 759, 244 Ill. Dec. 286 (2006) which involved a similar fact pattern, the Arbitrator finds petitioner sustained injuries in an accident that arose out of and in the course of her employment with respondent on January 26, 2016.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

Petitioner was taken by ambulance to the emergency room on Kishwaukee Hospital immediately after the accident where her complaints centered on her left knee, abdomen and also her left elbow. She denied head or spine pain. The next day she was seen by her PCP Rasmussen with excruciating pain in her left knee and was referred on the same day to Midwest Ortho Institute; her complaints were centered on her left thigh and knee.

As of February 3, 2016, PA Erlenbusch noted the leg hematomas were no longer noticeable. An MRI of the left knee was ordered, which was negative except for some chondromalacia. Even though she had not started physical therapy, she reported she was having a little bit of back pain. On February 10, 2016, physical therapy was order to get petitioner moving. On February 23, 2016, petitioner received her first physical therapy treatment to her knee. On March 2, 2016, due to the fact petitioner had fallen, PA Erlenbusch decided to look into petitioner's lumbar spine and ordered MRI. The fact that petitioner testified her lumbar pain came on in March, 2016, while doing physical therapy, is inconsistent with these medical records. Nonetheless, Dr. Faubel determined petitioner had a herniated disc at L4-5 with radiculopathy and weakness. However, spine surgeon, Dr. Shukairy, found petitioner's herniated disc was on the right and did not correlate with her left-sided symptoms. Petitioner was discharged from physical therapy having cancelled 13 times and was a no-show for seven visits.

As for the cervical spine, petitioner was seeing her PCP for cervicalgia and pain in both shoulders as well as her right thumb as of February 24, 2016. The cervical CT scan was negative. She was eventually evaluated by spine surgeon, Dr. Shukairy on April 23, 2016. The exam was normal except for some weakness on the left. Dr. Shukairy ordered a cervical MRI and an EMG of the upper extremities. The cervical MRI showed disc protrusions with impingement at C6-7. The EMG was negative. There was no Spurling or Lhermitte sign. There was no medical evidence tying petitioner's cervical condition to the work accident.

Despite the positive EMG finding of bilateral S1 radiculopathy, as of February 14, 2017, Dr. Faubel opined that he could not find a clear cause of petitioner's cervical or lumbar pain.

On August 19, 2016, petitioner was found to have carpal tunnel syndrome on the left and was referred to Dr. Kenny. Dr. Kenny diagnosed possible mild carpal tunnel syndrome on the left. Dr. Kenny failed to offer an explanation as to how the left carpal tunnel condition diagnosed in August, 2016 was related to the work accident of January 26, 2016.

Petitioner testified she had ongoing, rather bizarre, symptoms; which she related to the work accident. These complaints are not supported by the medical evidence.

Respondent did not offer any contrary medical evidence. Nonetheless, the Arbitrator finds petitioner failed to prove that her ongoing complaints of cervical and lumbar pain are related to the work accident of January 26, 2016.

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

The evidence supports a finding that the treatment from Midwest Orthopaedic Institute to the date of April 23, 2016 were reasonable and necessary to treat petitioner for her work injuries and awards the total sum of $10,336.08.

The evidence also supports a finding that the treatment at Center for Family Health on January 27, 2016 and February 10, 2016 was reasonable and necessary to treat petitioner for her work injuries and awards the sum of $1,224.14 for this treatment.

The total award of $11,560.22 for medical treatment is to be paid in accordance with the fee schedule and pursuant to §8 and §8.2 of the Act with credit to be given to respondent for all payments made.

K. With respect to the Arbitrator's decision with regard to TTD, the Arbitrator makes the following conclusions of law:

Petitioner was kept off work by her treating doctors for a myriad of problems from the date of accident to March 29, 2017. However, on April 23, 2016, spine surgeon, Dr. Shukairy determined petitioner's symptoms on the left did not correlate with the right-sided L4-L5 disc protrusion. Petitioner failed to prove her cervical and ongoing lumbar spine condition, as well as her left carpal tunnel syndrome, were caused by the work accident. And thus, petitioner failed to prove she was disabled after April 23, 2016 as a result of the work accident.

Accordingly, the Arbitrator finds petitioner was disabled from January 27, 2016 to April 23, 2016 and awards temporary total disability for said period, which is 12-4/7 weeks, at the rate of $272.87 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's initial complaints of injury involved her left knee, abdomen and left elbow. Her complaints evolved to include the cervical and lumbar spine as well as possible left carpal tunnel syndrome. There was minimal, if any, objective evidence to substantiate petitioner's claimed permanent injury to any part of her body.

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 as an office support specialist which is mostly sedentary. Therefore, the Arbitrator gives little to 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 49 years of age. Therefore, 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 found no longer to be disabled as of March 29, 2017. Therefore, petitioner has no 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 none of the treating medical records support any objective evidence of ongoing disability with the exception that the lower extremities EMG performed by Dr. Faubel on June 28, 2016 showed bilateral S1 radiculopathy. However, the same Dr. Faubel, stated on February 14, 2017 he could not find a clear cause of petitioner's cervical and lumbar pain.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 5% loss of use of person as a whole under §8 (d) and awards 25 weeks PPD at the rate of $253.00 per week. (Although petitioner claims in her proposed decision that she was married had two dependents, the Request for Hearing is silent on the issue of dependents and petitioner failed to testify on the issue.)

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	04WC013698
Case Name	RIZO, AURELIA v. ILL STATE POLICE-CRIME LAB
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0208
Number of Pages of Decision	25
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Danielle Curtiss

DATE FILED: 4/21/2021

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

Aurelia Rizo,

Petitioner,

vs. NO: 04 WC 13698

Illinois State Police – Crime Lab,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, causal connection, medical expenses, notice, 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 31, 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: **4/21/2021**

MP:yl
o 4/15/21
68

/s/ *Marc Parker*

/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0208

RIZO, AURELIA
Employee/Petitioner

Case# **04WC013698**

04WC013699
04WC013700
04WC013736
06WC068341
10WC039044

ILLINOIS STATE POLICE-CRIME LAB
Employer/Respondent

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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
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

JUL 31 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aurelia Rizo
Employee/Petitioner

v.

Illinois State Police – Crime Lab
Employer/Respondent

Case # **04** WC **13698**

Consolidated cases: **04 WC 13699, 04 WC 13700, 04 WC 13736, 06 WC 6834, 10 WC 39044**

An *Application for Adjustment 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 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. [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 [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On each of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**94,885.96**; the average weekly wage was $**1,824.73**.

On the dates of accident, Petitioner was **36, 40, 42, 43, 45, and 50** years old, respectively, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,216.49**/week for **9** weeks, commencing **June 4, 2008 through July 29, 2008, September 28, 2010 through October 2, 2010, February 8, 2013, and April 12, 2013**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for all temporary total disability benefits that have been paid.

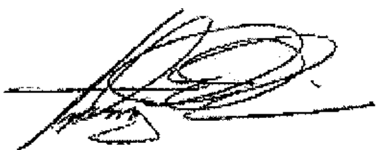
Respondent shall pay reasonable and necessary medical services of $**60,989.92**, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **135** weeks, because the injuries sustained caused the **27**% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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



Arbitrator Anthony C. Erbacci

JUL 3 1 2019

July 23, 2019
Date

FACTS:

The Petitioner testified that she became employed by the Respondent as a forensic scientist on April 1, 1982 and that she continued in that employment until she retired on May 31, 2013. The Petitioner described her job duties as requiring repetitive fine motor skills and the use of a computer. Specifically, she described that she was required to cut open packages of drugs for analysis, and to input her findings into a computer. The Petitioner described that she would run tests to identify the contents of multiple items in each case, some containing up to several hundred individual pieces. These items were most often in multiple small bags or in large, wrapped packages. The Petitioner testified that she would open the items packaged in small bags using forceps and tweezers, and then sample them for testing using a spatula the thickness of a USB cord. The items packaged in large bags were often wrapped in 3-5 layers of plastic, duct tape, oil, and dryer sheets, which the Petitioner would have to cut through with an X-acto knife in order to sample and weigh the materials inside.

The Petitioner testified that she would weigh all specimens individually, take samples and place them into small glass vials the size of a fingernail, or pipette the samples using a dropper bottle. The vials the specimens were placed into needed to be crimped and uncrimped with a squeezing motion so they could be tested. The Petitioner testified that she also frequently used pliers, scissors, pens, scalpels, and X-acto knives with her right hand. The Petitioner testified that her work also involved squeezing a manual scanner to sign in evidence and carrying boxes of evidence from the evidence storage area to her workstation.

The Petitioner claims to have been injured six times during the course of her employment with the Respondent: first on January 9, 1996, then on February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Claim Number 04 WC 13698

The Petitioner testified that on January 9, 1996, she was working on a multi-item drug case that required her to open tiny bags with forceps and tweezers, sample each item with a spatula, and follow the protocol required for each case: weigh the sample, take a sample of one set using a dropper bottle for a color test, take another sample, dilute it, and place it into an instrument using a capper, and then type the information into the computer and repackage and mark every single item. The Petitioner testified that by the time she was done with this particular case, her right hand had turned purple and cold to the touch, and she had pain in her right forearm all the way up to her right shoulder and neck. The Petitioner testified that her arm was in such pain that she had difficulty pushing a door open to leave the room. The Petitioner testified that she told her direct supervisor, Sally Dillon, about the incident and her pain.

A "Supervisor's Report of Injury or Illness" was eventually completed by Sally Dillon on May 2, 1996. In this report, it is noted that on January 11, 1996 the Petitioner reported an injury on January 9, 1996 when she experienced intense pain in her right wrist area, thumb, palm and forearm while taking samples of evidence.

The Petitioner testified that she continued to work following that incident and then sought treatment from Dr. Richard Brannegan for her right shoulder, arm and hand pain. A March 27, 1996 letter report from Dr. Brannegan, addressed to Dr. John Olivieri at Meyer Medical, was admitted into

the record as Petitioner's Exhibit 4. The Arbitrator notes that no records of treatment from Dr. Olivieri were offered into evidence. In his report, Dr. Brannegan noted that the Petitioner likely had an overuse syndrome with pain in the right hand and wrist coming from local sources such as the tendons and soft tissues of the forearm. Dr. Brannegan also noted that Petitioner's work demanded a fair amount of repetitive fine hand movement which aggravated the problem. He recommended some anti-inflammatory medications, splinting of the hand, and physical therapy.

On July 9, 1996, it was noted that the Petitioner then attended 13 sessions of physical therapy for thoracic outlet syndrome at HealthSouth, which were apparently prescribed by Dr. Olivieri. On July 8, 1997, the Petitioner underwent a Functional Capacity Evaluation at Health South which indicated that Petitioner could work in the medium demand level and perform all activities of her job.

Claim Number 04 WC 13699

The Petitioner testified that on February 8, 2000, she was injured for a second time when working several multiple-item drug cases on the same day. The Petitioner testified that, for each item in each case, she would follow the same steps to test, inventory, repackage, and mark the exhibit. She testified that by the end of the day, her right hand was purple and tingling with severe pain through her wrist and arm. A "Notice of Injury" form was completed on February 22, 2000 wherein the Petitioner reported an injury to her right hand, right wrist, neck, right shoulder, and right forearm. Timely notice of this injury is not disputed.

Following the February 8, 2000 injury, the Petitioner sought treatment with Dr. William Baylis at Parkview Musculoskeletal Institute on February 29, 2000. Petitioner complained of four to five years of right-hand medial elbow pain radiating to her right side of her neck, and also noted the poor ergonomic environment of her job and her job duties. Dr. Baylis prescribed a custom forearm splint and an EMG test which was performed on March 8, 2000 and reported to be normal study. On March 16, 2000, Dr. Baylis ordered an ergonomically correct workstation for Petitioner and limited her repetitive motion to four hours out of an eight-hour workday.

The Petitioner then sought treatment with a chiropractor, Kurt James Keppner, D.C. Dr. Keppner's impression was that the Petitioner sustained a repetitive motion injury to the cervico-thoracic spine, and he recommended chiropractic care.

On November 20, 2000, the Petitioner was examined by Dr. Michael Bednar at the request of the Respondent. Dr. Bednar's impression was that Petitioner likely had a variant of thoracic outlet syndrome. He agreed with Dr. Baylis' plan for improving Petitioner's ergonomic work situation. He opined that additional physical therapy and chiropractic manipulation would not improve her condition and that she would not benefit from surgery. Dr. Bednar indicated that the Petitioner was not at a level of maximal medical improvement, and he recommended that she get an ergonomically improved workstation and continue with Dr. Baylis' restrictions of limiting repetitive work to only 50 percent of Petitioner's workday.

On April 24, 2001 Dr. Bednar noted that some ergonomic changes had been made to the Petitioner's workstation which she felt had improved some of her symptoms. On June 1, 2001Dr. Bednar noted that an MRI of the Petitioner's cervical spine had been completed and demonstrated

som mild stenosis at C6-7. Dr. Bednar then referred the Petitioner to Dr. Alexander Ghanayem at Loyola.

On June 27, 2001, the Petitioner saw Dr. Ghanayem who indicated that her MRI findings were incidental and did not correlate with her symptoms. Dr. Ghanayem did not believe that the Petitioner had a cervical spine etiology for her right upper extremity symptoms.

Claim Number 04 WC 13700

The Petitioner testified that on July 3, 2001, she was injured for a third time. The Petitioner testified that, for some time, she had been breaking up her day to avoid repetitive tasks but, on this date, she was working on a case where 14,055 grams of plant material were wrapped in layers of saran wrap, duct tape, and dryer sheets. The Petitioner testified that she cut the package open with a scalpel and X-acto knife, sampled it, and repackaged it. She testified that while repackaging the item, she experienced extreme pain in her right hand, wrist, fingers, arm, shoulder, neck and elbow.

A "Notice of Injury" form was eventually completed in which the Petitioner described an injury to her right hand which felt numb, cold, and tingly. She also reported that her right arm and right wrist area hurt the entire day and evening, and her right hand, right wrist, neck and right shoulder ached for several days. Timely notice of this injury is not disputed.

Following the July 3, 2001 injury, the Petitioner returned to Dr. Bednar at Loyola on August 14, 2001. Dr. Bednar noted that the Petitioner's symptoms were now more significant for numbness and tingling in the median nerve distribution. Dr. Bednar placed Petitioner on a 20 lbs. work restriction and discussed a future EMG test. Petitioner was also sent for biofeedback and occupational therapy which was performed at Rehabilitation Institute of Chicago. The Respondent accommodated the Petitioner's physical restrictions.

On November 13, 2001, Petitioner returned to Dr. Bednar, who noted no point tenderness, and that Petitioner could return to work without restrictions. However, Dr. Bednar also told Petitioner to change her tasks over the day and not be as repetitive. Dr. Bednar placed Petitioner at maximum medical improvement on this date.

The Petitioner then saw Dr. John Shea, a neurosurgeon at Loyola, from March to May of 2002. Dr. Shea noted right sided neck pain radiating to the right arm and hand and tingling into the right hand. Dr. Shea reviewed Petitioner's cervical MRI and did not see evidence of thoracic outlet syndrome. He allowed Petitioner to continue to work with the restrictions of Dr. Bednar.

On June 18, 2002, Dr. Bednar saw Petitioner again and his current diagnosis was pain of the neck and arms which are of undefined etiology. Dr. Bednar referred Petitioner to Dr. William Sullivan at Loyola in the physical medicine and rehabilitation department, to see if there was any further treatment available for Petitioner. Petitioner was allowed to return to work full duty without restriction on June 19, 2002. Dr. Bednar did note that the Petitioner's symptoms increased during the workday and aggravated her current condition, and that it was difficult to determine when she would reach maximum medical improvement.

On July 17, 2002, the Petitioner saw Dr. Sullivan who noted a diagnosis of chronic pain likely of myofascial origin in the shoulder and scapular regions. Dr. Sullivan showed Petitioner exercises, prescribed medications, and stated she was at maximum medical improvement. Dr. Sullivan recommended Petitioner take breaks throughout the workday.

Claim Number 04 WC 13736

The Petitioner testified that on November 25, 2003, she was injured for a fourth time. The Petitioner testified that over several days, she worked on a drug case that contained 57 small item baggies. The Petitioner testified that for each item, she was required to open the bag, weigh the specimen, mark it, write down the weight, complete preliminary testing on the color of the specimen using a dropper bottle, take another sample with the spatula, clean it off, mark the vial, add a solvent, use a pipette to decant the liquid into another vial, then crimp or screw the cap on a vial and mark it. The Petitioner testified that she needed to take frequent breaks and do her prescribed stretching throughout the project. She testified that she completed the case successfully, but experienced excruciating pain from holding the scalpels, pens, scissors, and other small and thin tools. She testified that the pain was tingling and radiated from her right thumb and wrist up to her elbow, right shoulder, and right neck. She reported the injury to her supervisor.

An "Employer's First Report of Injury" form was eventually completed and indicated a work accident of November 25, 2003 from repetitive motion while Petitioner was opening 57 bags of specimens for analysis. The report mentioned right shoulder and neck pain.

On February 6, 2004, the Petitioner sought treatment with Dr. Charles Carroll. Dr. Carroll noted a history of Petitioner's significant workload that involved multiple bags of data, wherein she developed pain in the shoulder, elbow, and hand. She complained of pain in the right neck, right chest, subclavicular region anterior shoulder, and along the course of the ulnar nerve. Dr. Carroll noted numbness and tingling in the right hand consistent with carpal tunnel syndrome. Dr. Carroll noted that there was evidence of right thoracic outlet syndrome and mild evidence of left thoracic outlet syndrome. Her neurological exam also showed evidence of ulnar neuritis and carpal tunnel syndrome. Dr. Carroll also noted possible shoulder instability. He recommended physical therapy and an MRI. He also allowed Petitioner to continue working but to not do heavy lifting and to vary her job tasks.

The Petitioner participated in physical therapy and occupational therapy at Northwestern Center for Orthopedics. She also underwent an MRI of the right shoulder on February 12, 2004 at High Tech Medical Park which was a normal study.

On February 23, 2004, Petitioner returned to Dr. Carroll who reviewed prior medical records and diagnostic studies. Dr. Carroll noted several positive physical and neurological examination findings and indicated that Petitioner had evidence of neuritis at the ulnar nerve and carpal tunnel region, even in the face of normal electrodiagnostic studies. She also had evidence of possible cervical radiculitis. Dr. Carroll recommended continued physical therapy, and an MRI of the cervical spine. He allowed Petitioner to continue working but instructed her to vary her job duties. Dr. Carroll considered Petitioner's present condition of ill-being to be aggravated by the work that she does.

Petitioner continued therapy, but with OccuSport physical therapy, throughout March and April 2004. On March 20, 2004, the Petitioner underwent a cervical MRI at High Tech Medical Park.

On May 5, 2004, Dr. Carroll noted a diagnosis of cervical spondylosis based on the March 20, 2004 MRI. Dr. Carroll recommended that Petitioner see Dr. Srdjan Mirkovic for the cervical condition and indicated that he has not yet determined that the cervical spine is the sole cause of her arm pain. Dr. Carroll noted that the Petitioner was not at maximum medical improvement but could continue working exercising care with highly repetitive activities.

Petitioner saw Dr. Mirkovic at Northwestern on June 16, 2004. Dr. Mirkovic noted complaints of neck and right arm pain radiating to the elbow and occasionally the hand with right shoulder pain. Dr. Mirkovic opined that the Petitioner's current symptoms were an aggravation of a pre-existing cervical spondylosis and he recommended a CT myelogram of the cervical spine.

The CT Myelogram was performed on August 2, 2004. Dr. Mirkovic reviewed the CT myelogram on August 17, 2004 and noted foraminal stenosis on the right at C4-5 greater than C5-6. Dr. Mirkovic noted that some of Petitioner's symptoms may be emanating from nerve root compression secondary to the foraminal stenosis. He discussed possible surgical options and recommended right C5 and C6 nerve root blocks.

On October 20, 2004, Dr. Jeff Katz performed the cervical epidural steroid injection to Petitioner's right C5-6. He noted that Petitioner's neck and shoulder felt 50 percent better after the injection. Her thumb pain was unchanged. She did not have any pain in the medial forearm, but also didn't have much pain in the forearm prior to the injection on this date. Dr. Katz noted that Petitioner could continue regular work duties but must wear an elbow pad for ulnar neuritis.

On November 9, 2004, Dr. Mirkovic noted Petitioner's benefit from cervical injection and recommended another injection. He diagnosed foraminal stenosis with radiculopathy.

Claim Number 06 WC 6834

The Petitioner testified that on November 3, 2005, she sustained a fifth injury. She testified that she had been working on a case that contained 51 items in paper bags. She had to perform the same series of steps on these items as with all the other cases, which resulted in severe pain in her right hand, right thumb, right wrist, right elbow, right shoulder, and neck. She told her supervisor on that date that she needed medical treatment. Timely notice of this injury is not disputed.

On February 17, 2006, the Petitioner returned to Dr. Carroll and complained of pain in the right elbow. Dr. Carroll diagnosed right lateral epicondylitis, cervical radiculitis, and sprains and strains of the right wrist and right hand. He ordered a new thumb Spica splint and allowed Petitioner to continue full duty work. Dr. Carroll considered the conditions work-related. Petitioner began physical therapy at OccuSport which she performed for six weeks.

The Petitioner returned to Dr. Carroll on April 14, 2006 and he noted Petitioner complained of chronic pain in the right elbow and some discomfort in the right lateral epicondyle. She also still had neck and right shoulder complaints. Dr. Carroll diagnosed triceps tendonitis and lateral epicondylitis.

Dr. Carroll referred Petitioner to Dr. Mirkovic and kept her at full duty. Petitioner continued physical therapy.

The Petitioner returned to Dr. Carroll on June 12, 2006 and he noted that her neurologic examination confirmed some epicondylitis and ulnar neuritis. Dr. Carroll recommended the Petitioner continue working, consider seeing a physiatrist, and follow up with a spine surgeon.

On August 1, 2006, Petitioner saw Dr. Mirkovic, who noted neck pain, right scapular and shoulder pain, and right arm ache. He prescribed an MRI of the cervical spine, and an EMG/NCV study of the upper extremity.

Petitioner underwent a cervical spine MRI on August 4, 2006 which showed multilevel degenerative changes. An EMG/NCV study performed on August 4, 2006 was reported to be an abnormal study indicative of chronic, mild, right C5-7 cervical polyradiculopathy without evidence of ongoing denervation. There was no electrodiagnostic evidence of a right medial mononeuropathy at the wrist or ulnar mononeuropathy.

Petitioner sought treatment with Dr. Brian Couri of the Chicago Institute of Neurosurgery and Neuroresearch on August 14, 2006. Dr. Couri's assessment included; 1) right-sided snapping scapula secondary to scapular stabilizing muscle weakness which is very prominent with significant scapular dysfunction; 2) right medial and lateral epicondylitis most likely due to overuse from the scapular dysfunction; 3) positive Hawkins' sign on the right side with right-sided impingement syndrome which is probably secondary to the scapular dysfunction with rotator cuff overuse and the weakness of the rotator cuff muscles; 4) bilateral neck pain over bilateral C2-3, C3-4, and C4-5 cervical zygapophyseal joints with left-sided osteoarthritis and right C1-2 zygapophyseal joint dysfunction, probably more secondary to the muscle imbalances but could very well be due to discomediated pain causing some pain in the cervical spine and leading to the capsular dysfunction; 5) Right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis which very well could be causing the patient to have the cervical spine pain and the shoulder pain leading to the scapular dysfunction which is the main cause of all of the rest of the patient's current symptoms; 6) Right-sided thoracic outlet syndrome, more prominent than that on the left side, which is more than likely functional in nature as opposed to any true impingement upon the thoracic outlet. It is probably more functional due to the scapular stabilizing weakness. Dr. Couri prescribed physical therapy and allowed Petitioner to continue full duty work.

Petitioner continued physical therapy at OccuSport and followed up with Dr. Couri. On October 9, 2006, Dr. Couri's assessment was a right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis; 2) right-sided functional thoracic outlet syndrome; 3) what appears to be a right very mild C5 radiculitis/radiculopathy; 4) right scapular dysfunction with shoulder impingement secondary to the C5 radiculopathy. Dr. Couri recommended a right C5 transforaminal epidural steroid injection, which was performed on October 31, 2006.

On November 7, 2006, the Petitioner was involved in an unrelated motor vehicle accident. The Petitioner testified that she was hit while making a U-turn and suffered *left* upper trapezius muscle pain and *left-sided* neck pain, neither of which exacerbated the right-sided neck pain she was experiencing from her work injury. The Petitioner testified that there was no injury to her right upper extremity in this automobile accident.

On November 13, 2006, Petitioner attended physical therapy with OccuSport and the therapist noted that Petitioner's recent motor vehicle accident affected the left upper trapezius and had no effect on the work-related right side. It was noted that the Petitioner reported an overall improvement in her right-sided symptoms since her epidural injection on October 31, 2006. On November 14, 2006 Dr. Couri noted that the motor vehicle accident caused left scapular/shoulder-area spasms and increased left sided neck pain, but that her right-sided neck pain did not become any worse. He allowed Petitioner to continue working full duty.

Dr. Couri performed additional injections to the right C2-3, C5-6, and C6-7 zygapophyseal joints on December 19, 2006. Petitioner continued therapy.

On February 2, 2007, Petitioner saw Dr. Couri again and he recommended that Petitioner continue full time work but to do one-third less cases, and to instead spend that time doing something like teaching which she had done in the past. Dr. Couri ordered another EMG/NCV test of the right arm and an elbow injection.

An MRI arthrogram of the Petitioner's right shoulder was performed on June 14, 2007 at Future Diagnostics Group and was reported to be unremarkable.

The Petitioner was then referred by Dr. Couri to Dr. Giridhar Burra at Hinsdale Orthopedic Associates on June 22, 2017. Dr. Burra noted several positive physical exam findings relative to the right shoulder. Dr. Burra reviewed diagnostics and made a diagnosis of biceps tendinitis and a possible superior labrum anterior and posterior lesion. Dr. Burra recommended a diagnostic right shoulder arthroscopy.

On July 16, 2007, Petitioner returned to Dr. Couri who agreed with Dr. Burra's plan of diagnostic right shoulder arthroscopy. Dr. Couri stated that "it appears all of her symptoms came about with chronic repetitive work and lifting of heavy objects, and I believe that her right shoulder is the main cause of her symptoms which has exacerbated the neck and now the elbow." Dr. Couri placed Petitioner on 10 lbs. lifting restrictions and no overhead work.

On August 1, 2007, Petitioner was involved in another unrelated motor vehicle accident. She was taken to Silver Cross Hospital and complained of a left upper arm abrasion, a right shoulder abrasion, and mid lower back pain. The Petitioner testified that she only experienced slight soreness on her left side as a result of this accident.

On September 21, 2007, Dr. Burra authored a letter indicating that Petitioner's right shoulder/bicep symptoms preceded the motor vehicle accident and that she never had relief of symptoms prior to the motor vehicle accident. Accordingly, Dr. Burra opined that her shoulder symptoms were primarily related to her work injury and did not believe that the motor vehicle accident caused the injury.

On June 4, 2008, the Petitioner underwent right shoulder surgery at Silver Cross Hospital with Dr. Burra. The post-operative diagnosis was a SLAP lesion, subacromial bursitis and mild impingement in the right shoulder. The procedure consisted of right shoulder arthroscopy, SLAP lesion repair and subacromial decompression. Following surgery, Petitioner continued following up with Dr. Burra and performing physical therapy.

On November 19, 2008, the Petitioner reported to Dr. Burra that her right shoulder was doing well with increasing motion. However, she had a complaint on this date of rather extreme exacerbation of left elbow epicondylitis. She was diagnosed with left lateral epicondylitis. Dr. Burra recommended therapy for both the right shoulder and left elbow, and to remain restricted at work.

On January 7, 2009, Dr. Burra noted that Petitioner had made great progress with the right shoulder and could discontinue therapy and progress to a home exercise program. Dr. Burra placed Petitioner on restrictions for the right shoulder of no lifting greater than 25 lbs. and recheck in 6 weeks. Relative to the left elbow, Petitioner still complained of left elbow pain, worse with any gripping or lifting. Dr. Burra recommended a cortisone injection and continuation of physical therapy. The injection was done on this date. Dr. Burra also placed restrictions of no gripping with the left arm.

On April 17, 2009, Dr. Burra noted that Petitioner was pretty much asymptomatic for the right shoulder. He placed Petitioner at maximum medical improvement for her right shoulder and allowed her to return to full duty without restriction. However, for her continued right elbow symptoms, Dr. Burra noted that Petitioner had previous complaints suggestive of ulnar neuritis. He also noted that people with shoulder surgeries are at a higher risk because of the significant amount of flexion with performance of the rehab and immobilization after shoulder surgery, and this would put this condition for an exacerbation. He diagnosed ulnar nerve neuropathy and recommended a night splint. For the left elbow, Dr. Burra performed another injection and discussed possible surgical intervention if not improved. She was returned back to work with restrictions of no gripping with the left hand.

On June 25, 2009, the Petitioner saw Dr. Burra and reported that she was symptomatic in regard to her right elbow, complaining of paresthesia to the right ulnar nerve distribution. She was also tender over the left lateral epicondyle in the left elbow. Dr. Burra stated that "her right shoulder pathology [was] related causally to her right elbow symptoms..." For the left elbow lateral epicondylitis, he stated it is not a traumatic condition but an overuse syndrome. Dr. Burra discussed surgical options and recommended an MRI of the left elbow. A left elbow MRI was performed on July 9, 2009 at Future Diagnostics Group.

Dr. Burra reviewed the MRI of the left elbow on July 29, 2009 and diagnosed left epicondylitis. However, Petitioner reported improvement in her symptoms, and wanted to defer any surgical intervention unless symptoms worsen. Dr. Burra allowed her to continue to work with limitations of no repetitive gripping in the left hand, and to follow-up as needed.

On August 1, 2009, the Petitioner returned to Dr. Mirkovic for neck and right shoulder pain, and he ordered an MRI of the cervical spine and an EMG/NCV of the right upper extremity.

The Petitioner returned to Dr. Burra on December 2, 2009 complaining of increased right shoulder pain that freezes, cracks and pops, as well as increased pain with overhead activities or reaching behind or across her body. Dr. Burra diagnosed right elbow lateral epicondylitis as well as cubital tunnel syndrome. He recommended a repeat MRI arthrogram, and also to return after the EMG was done relative to the right elbow.

The Petitioner returned to Dr. Burra on January 6, 2010. Despite a negative EMG, Dr. Burra felt that the Petitioner had left elbow cubital tunnel syndrome and recommended ulnar nerve transposition surgery. For the right elbow, he diagnosed lateral epicondylitis, and recommended conservative treatment. Relative to the right shoulder, the MRI arthrogram showed some post-

surgical changes, but Dr. Burra recommended trying to manage it conservatively. The Petitioner was kept on restrictions of no repetitive gripping and no lifting greater than 5 lbs.

On July 2, 2010, the Petitioner had another EMG with Dr. Wayne Kelly of Health Benefits Pain Management. The EMG was noted to be abnormal, and the impression was 1) a right-sided chronic underlying chronic C6-7 cervical radiculopathy with evidence of primarily chronic axonal involvement; 2) a superimposed right-sided mild chronic compression/entrapment ulnar neuropathy across the elbow (Cubital tunnel syndrome) with evidence of mild focal demyelination and mild chronic axonal involvement, likely indicative of a double crush injury; 3) a bilateral moderate chronic compression/entrapment median mono neuropathies at the wrist (carpal tunnel syndrome) with evidence of moderate focal demyelination of both sensory and motor nerves as well as chronic axonal involvement; 4) no electrophysiological evidence of an underlying sensory/motor polyneuropathy or right brachial plexopathy. Dr. Kelly recommended two C6-7 cervical injections, a right ulnar nerve steroid block along the ulnar nerve, and a right distal medial nerve steroid block at the carpal tunnel and use of cock-up wrist splints.

Claim Number 10 WC 39044

The Petitioner testified that on August 2, 2010, she was injured for a sixth time when working on a case with several kilos of plant material wrapped in multiple layers of saran wrap. The Petitioner testified that she was using an X-acto knife to cut open the packages and enter the information into the computer. By the time she was done analyzing, sampling, and repackaging, her right and left hands, wrists, and thumbs were in significant pain.

The Petitioner reported the incident to her supervisor and an accident report was eventually completed. The Petitioner reported in the accident report that she was opening packaged kilos of cannabis. She had to cut open the package and remove the cannabis for weight and analysis. During these job duties, she felt pain in her right wrist, right elbow, left wrist, and bilateral hands. Timely notice of this injury is not disputed.

On August 16, 2010, the Petitioner returned to Dr. Burra, and she reported that her right shoulder pain was significantly resolved, and her left elbow pain was improved. She complained, however, that she was very limited and affected by her right elbow pain. She reported the recent work activity of opening multiple kilo packs which involved significant flexion/extension across her right elbow and had worsened her symptoms. Dr. Burra reviewed the EMG from July 2010. Dr. Burra indicated that Petitioner had a double crush condition. Dr. Burra recommended ulnar nerve transposition surgery.

Surgery was performed on September 28, 2010 to the right elbow. The pre-and-post operative diagnosis was ulnar nerve compression neuropathy of the right elbow. The procedure performed consisted of right-side ulnar nerve anterior transposition with a subcutaneous technique. Petitioner was placed on sedentary work/paperwork only duties.

Petitioner continued following-up with Dr. Couri in 2010 and did physical therapy for the post-operative right elbow.

On November 17, 2010, Dr. Burra recorded that Petitioner's numbness and tingling in her right 4th and 5th fingers was resolving post-surgery. Her left elbow was asymptomatic as of this date. Dr. Burra placed Petitioner on continued work restrictions.

On December 28, 2010, Dr. Burra noted that the Petitioner's right 4th and 5th finger symptoms had resolved. Her right elbow was doing much better. Noting that the Petitioner's right elbow, right shoulder, and left elbow symptoms were under control, Dr. Burra released her from his care. Dr. Bura indicated that the Petitioner was able to return to work relative to the right elbow, right shoulder and left elbow, but he noted that the Petitioner was still treating with Dr. Couri for carpal tunnel syndrome.

The Petitioner continued treatment with Dr. Couri in early 2011 for bilateral carpal tunnel syndrome. On January 10, 2011, she complained of bilateral hand symptoms which were improving. She still had a complaint of left elbow pain at this visit and she reported that her work aggravated both conditions. Dr. Couri kept Petitioner on work restrictions.

On March 25, 2011, Dr. Couri performed a left eblow lateral epicondyle injection, and instructed Petitioner to continue using a cock-up wrist splint. She was kept on work restrictions. On April 19, 2011, Dr. Couri recommended another cervical MRI, and kept Petitioner on work restrictions.

On May 23, 2011, Dr. Couri reviewed the April 26, 2011 MRI. Petitioner reported doing better with the left elbow pain since the injection. She was still having mild left lateral elbow pain and left sided neck pain. Dr. Couri recommended left C6 and C7 transforaminal epidural steroid injections and physical therapy, which Petitioner wanted to defer for the time being. She would instead try a home traction unit for one to two weeks first. She was kept on work restrictions. Dr. Couri performed an additional left elbow injection on August 2, 2011.

The Petitioner continued following up with Dr. Couri in 2012. By October 1, 2012, Dr. Couri noted that Petitioner had bilateral wrist pain and weakness. She reported numbness and tingling with fine motor activities, and also decreased grip. Dr. Couri's diagnoses was bilateral moderate carpal tunnel syndrome. He discussed bilateral percutaneous carpal tunnel release surgery in the future. She was kept on work restrictions.

On October 26, 2012, Petitioner underwent bilateral *percutaneous* carpal tunnel release surgeries with Dr. Couri.

She returned to Dr. Couri on December 6, 2012 who noted that the carpal tunnel releases had failed. He referred the Petitioner to Dr. John Fernandez at Midwest Orthopedics at Rush for another opinion.

The Petitioner saw Dr. Fernandez for the first time on January 9, 2013, and he diagnosed the Petitioner with bilateral carpal tunnel syndrome, bilateral thumb CMC joint osteoarthritis, and bilateral upper extremity pain. He recommended bilateral carpal tunnel release procedures.

On February 8, 2013, Petitioner underwent left wrist carpal tunnel release with Dr. John Fernandez. On February 25, 2013, Dr. Fernandez noted that Petitioner's paresthesias in the left hand had nearly completely resolved.

On April 12, 2013, Petitioner underwent right wrist carpal tunnel release surgery with Dr. Fernandez. Petitioner saw Dr. Fernandez on April 29, 2013, who noted improvement after right wrist surgery relative to numbness and tingling. Her main complaint on this day was pillar pain primarily worse on the right than left, worse with direct pressure of the palm and also worse with lifting activities. Dr. Fernandez noted that Petitioner could work with restrictions until June 1, 2013 at which time she would be at maximum medical improvement and able to return to full duty work.

The Petitioner testified that she lost one day of work for each carpal tunnel surgery and that the Respondent continued to accommodate her restrictions. She testified that she did less repetitive work and she participated in more teaching activities at work.

The Petitioner continued to work on restricted duty until May 31, 2013 when she voluntarily retired from her employment with the State of Illinois.

On May 27, 2015, the Petitioner returned to Dr. Fernandez with complaints of a bump/nodule on her left palm which was slightly tender to palpation and bothered her when performing gripping and working out activities. Relative to the right upper extremity, she complained of volar wrist pain. Her neurologic complaints from the median nerve distribution were completely resolved at this point. Dr. Fernandez performed a physical exam which noted a slight thickening of the surgical site along the left palm, and also a Dupuytren's nodule associated with the middle finger of the left palm. Relative to the right wrist, she had very minimal swelling along the volar aspect. She had full range of motion of the hand, wrist, and elbow. X-rays were performed which revealed ulnar positive variance by approximately 2mm. Dr. Fernandez' diagnoses were 1) left hand Dupuytren's disease, nodular phase; 2) bilateral upper extremity pain beginning while working as a chemist in 2012. Some medications were prescribed, and she was told to follow-up as needed.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

The Petitioner was examined at the request of her attorney by Dr. Samuel Chmell on October 15, 2015. Dr. Chmell's deposition testimony was admitted into the record as Petitioner's Exhibit 20. Dr. Chmell testified as to his understanding of the Petitioner's job duties and work history as well as her history of injuries and his examination findings. Dr. Chmell made the following seven diagnoses for the Petitioner: 1) bilateral carpal tunnel syndrome and multiple tendinitis, both wrists status post bilateral carpal tunnel releases times two; 2) right elbow cubital tunnel syndrome, status post ulnar nerve decompression and anterior transposition; 3) right shoulder SLAP lesion and impingement

syndrome, status post arthroscopy SLAP repair and subacromial decompression; 4) right shoulder snapping scapula syndrome; 5) bilateral elbow lateral and medial epicondylitis; 6) traumatic aggravation of degenerative disc disease in cervical spine with right upper extremity radiculopathy; and 7) right thoracic outlet syndrome.

Relative to causation, Dr. Chmell testified as to each of his seven diagnoses:

Relative to the bilateral carpal tunnel syndrome/multiple tendonitis hands and wrist, status post bilateral carpal tunnel release times two, Dr. Chmell testified that these conditions are causally related to Petitioner's work accidents of January 9, 1996, February 8, 2000, July 3, 2001, and August 2, 2010. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right cubital tunnel syndrome, status post ulnar nerve decompression and anterior decompression and interior transposition, Dr. Chmell testified that this condition was causally related to the July 3, 2001 and the August 2, 2010 work accidents. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right shoulder SLAP lesion and impingement syndrome status post arthroscopy, SLAP repair and subacromial decompression, Dr. Chmell testified that this condition was causally related to the work accident of November 25, 2003, which was aggravated on November 3, 2005. Dr. Chmell testified that this injury was a result of Petitioner's repetitive activities at work and that all treatment for those conditions to date has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right shoulder snapping scapular syndrome, Dr. Chmell testified that this condition is causally related to the November 25, 2003 work accident which was later aggravated during the November 3, 2005 work accident. Dr. Chmell testified that all treatment for this condition was reasonable, necessary, and causally related to the work accidents.

Relative to the diagnosis of bilateral elbow lateral and medial epicondylitis, Dr. Chmell testified that the right arm condition was causally related to the July 3, 2001 work accident and was further aggravated by the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell testified that the left elbow condition became involved after the August 2, 2010 work accident. Dr. Chmell opined that all treatment to date for these conditions has been reasonable, necessary, and related to the work accidents.

Relative to the diagnosis of cervical spinal traumatic aggravation of degenerative disc disease with right upper extremity radiculopathy, Dr. Chmell testified that this condition was causally related to the work accident of February 8, 2000, and further aggravated by the July 3, 2001, November 3, 2005, and August 2, 2010 work accidents. The condition was confirmed by positive EMG findings following the November 3, 2005 work accident. Dr. Chmell opined that all treatment to date for this condition has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right thoracic outlet syndrome, Dr. Chmell testified that this condition was causally related to the February 8, 2000 work accident, which was later aggravated during the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell opined that all

treatment for this condition to date has been reasonable, necessary, and related to the work accidents.

Dr. Chmell reviewed several accident reports which were included in Petitioner's Deposition Exhibit #4 at the deposition and noted that Petitioner's job duties as described in the reports are consistent with the type of activity that could cause the conditions he diagnosed.

Dr. Chmell opined that as of the date he saw Petitioner on October 15, 2015, Petitioner was at maximum medical improvement. Dr. Chmell also opined that Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma. Finally, Dr. Chmell testified that Petitioner's work restrictions in this case have been related to her work injuries.

Dr. Chmell testified that he disagreed with Dr. Verma's conclusion that the Petitioner's work was not consistent with a mechanism to cause A-C joint arthrosis or biceps tendon superior labral tearing. Dr. Chmell opined that repetitive motion activities can affect the shoulder when the labrum is stressed and eventually shreds and tears. Dr. Chmell further disagreed with Dr. Verma's conclusion that Petitioner reached MMI on March 17, 2008. Dr. Chmell disagreed because he believed Petitioner's shoulder surgery on June 4, 2008 helped her condition.

At the request of the Respondent, the Petitioner was examined by Dr. Nikhil Verma on March 17, 2008 and April 17, 2017 and he performed a record review on January 10, 2018. Dr. Verma's April 4, 2018 deposition testimony was admitted into the record as Respondent's Exhibit 20.

With regard to his examination of the Petitioner on March 17, 2008, Dr. Verma testified that he examined the Petitioner and reviewed the Petitioner's medical records from 2002 through 2007. Dr. Verma testified that he didn't review a written description of the Petitioner's job duties in preparation for the exam but the Petitioner described to him that her work as a forensic scientist involved using her hands for fine work, including opening small packages and testing substances and powders. Dr. Verma's diagnosis was right upper extremity pain with possible cervical spondylosis and radiculopathy. Dr. Verma did not believe this to be causally related to her job duties, because he did not locate a diagnosis within the shoulder that would be responsible for her symptoms, which he viewed to be diffuse in nature and not explained by the Petitioner's AC joint, biceps, or SLAP problems. Dr. Verma further testified that a repetitive use type mechanism is not consistent with a SLAP pathology in an individual of the Petitioner's age group.

Dr. Verma stated that degenerative changes in the labrum are common for patients in Petitioner's age group, and that the only repetitive use mechanism that generates SLAP tears is throwing a baseball at 80-plus miles per hour, which is not an activity in which he believed Petitioner was participating. Dr. Verma stated that repetitive work would be similarly inconsistent with superior labral pathology. Dr. Verma did not believe that the Petitioner's clinical exam findings supported the diagnosis of superior labral pathology, given their diffuse nature involving multiple components of her upper extremity.

Dr. Verma opined that Petitioner did not require any additional medical treatment for her shoulder related to a work injury, did not require any work restrictions, and was at maximum medical improvement.

With regard to his examination of the Petitioner on March 17, 2017, Dr. Verma testified that he reviewed the Petitioner's medical records from Dr. Burra, pain management records, records from Hinsdale Orthopedics, and records from Dr. Chmell. Dr. Verma noted that Petitioner's bilateral shoulders were normal aside from healed incisions on the right side and he indicated that the Petitioner demonstrated full range of motion, normal cervical motion, normal neurovascular systems, and no provocative testing findings on either shoulder. Dr. Verma opined that the Petitioner's right shoulder was essentially normal both objectively and subjectively. She had undergone right shoulder SLAP repair, which Dr. Verma did not believe was causally related to the work activities. Dr. Verma also opined that Petitioner was at maximum medical improvement for the shoulders, that no additional treatment was needed, and that she did not require any work restrictions relative to the shoulders.

With regard to his review of additional medical records of the Petitioner's treatment from 1996 through 2010, Dr. Verma testified that he also reviewed a job description in conjunction with authoring this report. Following his review of the updated records, Dr. Verma diagnosed the Petitioner with chronic upper extremity pain with possible fibromyalgia-type symptoms. Dr. Verma again stated that he did not believe Petitioner's condition to be causally related to her job duties.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

After reviewing all testimony and evidence, the Arbitrator hereby finds that the Petitioner did sustain accidents that arose out of and in the course of her employment by the Respondent on January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010. The accidents are supported by the Petitioner's testimony and corroborated by the accident reports and the treating medical records.

The respondent did not call any witnesses to dispute the Petitioner's version of her job duties or how the accidents occurred.

With regard to the issue of Notice, the Arbitrator notes that the Respondent only disputed the issue of timely notice with regard to the initial injury of January 9, 1996 (Claim Number 04 WC 13698). Based upon the Petitioner's unrebutted testimony, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Several of Petitioner's treating physicians provided opinions as to causation in this case over the years.

On March 27, 1996, while referring to Petitioner's soft tissue/tendons in the right forearm, Dr. Brannegan noted that "it sounds as if [Petitioner's] work demands a fair amount of repetitive fine hand movement, and this probably aggravates this problem."

Dr. Bayliss indicated in February and March of 2000 that Petitioner's symptoms are related to the ergonomics of her workstation and recommended altering the workstation.

Kurt James Keppner, D.C. noted on April 28, 2000 that Petitioner's condition has deteriorated over the last four months caused by her overuse at an ergonomically unsound workstation that places undue stress and strain on her neck and upper back.

On May 30, 2002, Dr. Shea at Loyola noted that "working aggravates all of her symptoms" while discussing Petitioner's neck, right arm, right thumb and grip strength.

On June 18, 2002, Dr. Bednar noted "I believe the work that she does aggravates her current condition." He also ordered her workstation be modified.

On February 6, 2004, Dr. Charles Carroll at Northwestern noted "[Petitioner] has an ongoing problem which has been further aggravated by her more recent work stress" while discussing a possible diagnosis of neuritis of the upper extremity. On February 26, 2004, Dr. Carroll stated, "I have considered her present condition of ill-being to be aggravated by the work that she discussed in previous correspondence."

Dr. Burra at Hinsdale Orthopedics stated on August 16, 2001 that "while the shoulder per se does not cause her ulnar nerve symptoms at the elbow... I have seen incidence or worsening of cubital tunnel syndrome following shoulder surgery because of the degree and duration of flexion that is required across the elbow both in the immediate postoperative period while she is in the sling as well as during the course of rehabilitative exercise and physical therapy following shoulder surgery, and I have seen this in my practice where there is an aggravation of this. As such, there is some relationship between her shoulder surgery and her elbow symptoms."

Dr. Burra also opined as to causation for the right shoulder SLAP lesion and biceps tendinitis in his September 21, 2007 correspondence. In this note, Dr. Burra opined that there is a clear-cut causal relationship of the work injury of November 3, 2005 to the right shoulder condition. He ruled out the auto accident as a cause of her condition.

Dr. Samuel Chmell, who examined the Petitioner at her attorney's request, testified that the sum of all the Petitioner's job duties involved repetitive stressful and difficult movements of Petitioner's upper extremities, right greater than left. He testified that the Petitioner did these tasks for 32 years, which was significant because her job duties subjected her upper extremities to repetitive motion activities, which is akin to overuse activities. Dr. Chmell testified that the Petitioner's job duties are consistent with the type of activity that could cause the conditions diagnosed in this case.

Dr. Chmell found seven diagnoses, which he opined were causally related to one or more of the work accidents in this case. Dr. Chmell noted that the Petitioner did not have any problems with her neck or upper extremities prior to working as a forensic chemist for the Respondent. Dr. Chmell

opined that the following seven diagnosed conditions were causally related to the Petitioner's work accidents:

1) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Nikhil Verma, the Respondent's examining physician, opined that Petitioner's diagnosis was chronic upper extremity pain with possible fibromyalgia-type symptoms. He did not feel that these conditions were causally related to her job duties. Dr. Verma only evaluated Petitioner relative to her bilateral shoulders and he did not evaluate her for any other body parts or conditions.

After reviewing all of the medical records, testimony and evidence, the Arbitrator finds the causation opinions of Petitioner's treating doctors to be consistent with the evidence and persuasive. The opinions and testimony of Dr. Samuel Chmell are credible and well-founded. Dr. Chmell's opinions correlate with those of Petitioner's treating doctors. Dr. Chmell also understood Petitioner's job duties consistent with Petitioner's testimony. While the Arbitrator notes the findings and opinions of Dr. Verma, the Arbitrator finds the causation opinions of the Petitioner's treating physicians, including Drs. Brannnegan, Carroll, Bayliss, Keppner, Shea, and Bednar to be persuasive. The Arbitrator also finds the opinions of Dr. Sam Chmell to be sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's work injuries on January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

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:

At trial, Petitioner submitted evidence of unpaid medical bills totaling $58,148.92, as summarized in Petitioner's Exhibit 31. Dr. Chmell testified that all medical treatment rendered to the Petitioner for her diagnosed conditions was reasonable, necessary, and causally related to the work accidents in this case. The Arbitrator hereby adopts the opinions of Dr. Chmell, which are sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof and finds that the unpaid medical bills totaling $58,148.92 set forth in Petitioner's Exhibit 31 are reasonable, necessary, and causally related to the work accidents of January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Additionally, the Petitioner submitted evidence of out-of-pocket travel/mileage costs as summarized in Petitioner's Exhibit 31. Section 8(a) of the Act states that the employer shall pay for treatment, vocational rehabilitation, and all services reasonably required to cure or relieve the effects

of the accidental injury. 820 ILCS 305(8)(a). Travel expenses are awarded in cases where it was reasonably necessary for the petitioner to travel in order to receive medical treatment. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). Here, the Petitioner's travel for treatment from 1996 through 2012 was for physical therapy, doctor's appointments, and testing, which all constitute reasonable travel expenses under the law. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate.

The Petitioner's mileage for travel to and from medical appointments as submitted in Petitioner's Exhibit 31 totals 17,629 miles. Applying the appropriate "IRS medical" rate applicable at the time of the travel, results in the total amount of $2,841.00 due. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate in the amount of $2,841.00.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she underwent surgery to her right shoulder on June 4, 2008 and that she was off work as a result of that surgery through July 29, 2008, a period of 8 weeks. The Petitioner testified that she underwent surgery to her right elbow on September 28, 2010 and that she was off work as a result of that surgery through October 2, 2010, a period of 5/7 weeks. The Petitioner underwent surgery to her left and right hands on February 8, 2013 and April 12, 2013, respectively, and that she was off work for one day after each of those surgeries, a period of 2/7 weeks. Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits for the periods of June 4, 2008 through July 29, 2008, a period of 8 weeks, September 28, 2010 through October 2, 2010, a period of 5/7 weeks, February 8, 2013, a period of 1/7 weeks, and April 12, 2013, a period of 1/7 weeks.

While the Petitioner claimed to be entitled to Temporary Partial Disability benefits for the hours of work that she missed obtaining treatment and therapy, the Arbitrator finds that the Petitioner failed to provide sufficient specific evidence of the actual periods of disability to allow the calculation of the exact amount of Temporary Partial Disability benefits that may be due, if any. The Arbitrator finds, therefore, that the Petitioner failed to meet its burden of proof with regard to what Temporary Partial Disability benefits, if any, are due. Accordingly, no Temporary Partial Disability benefits are awarded herein.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that Dr. Fernandez, the last physician who treated the Petitioner, noted that the Petitioner would be at maximum medical improvement by June 1, 2013 at which time she would be able to return to full duty work.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into

the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

Dr. Chmell, who examined the Petitioner at the request of her attorney on October 15, 2015, found seven diagnoses, which he opined were causally related to one or more of the Petitioner's work accidents:

2) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Chmell opined that the Petitioner was at maximum medical improvement. Dr. Chmell also opined that the Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a cumulative result of the Petitioner's six work injuries the Petitioner sustained permanent partial disability to her whole person to the extent of 27% thereof.

In Support of the Arbitrator's Decision relating to (N.), Is Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent claimed a credit under Section 8(j) of $17,894.58 (04WC13699); $3,955.04 (04WC13736); $33,044.57 (06WC6834). Respondent entered exhibits #13, 14, and 15 in support of their alleged 8(j) credit. Petitioner disputed the Respondent's entitlement to an 8(j) credit at the time of arbitration.

However, after the hearing on June 4, 2019, the parties entered into a stipulation on June 5, 2019 wherein they agreed that "the payments made by the Respondent referred to and contained in Respondent's exhibits 13, 14, and 15 were made by the workers' compensation claims department who administers, pays, and adjusts workers' compensation claims for the State of Illinois. The State

of Illinois is a self-insured employer under the Illinois Workers' Compensation Act. They are not payments made by a group insurance carrier."

The Arbitrator finds that the Respondent is entitled to credit for all of the 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	04WC013699
Case Name	RIZO, AURELIA L v. IL STATE POLICE CRIME LAB
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0209
Number of Pages of Decision	25
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Danielle Curtiss

DATE FILED: 4/21/2021

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aurelia Rizo,

Petitioner,

vs. NO: 04 WC 13699

Illinois State Police – Crime Lab,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, causal connection, medical expenses, notice, 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 31, 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: 4/21/2021

MP:yl
o 4/15/21
68

/s/ *Marc Parker*

/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIZO, AURELIA
Employee/Petitioner

Case# **04WC013698**

04WC013699
04WC013700
04WC013736
06WC006834
10WC039044

ILLINOIS STATE POLICE-CRIME LAB
Employer/Respondent

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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
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

JUL 31 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aurelia Rizo
Employee/Petitioner

v.

Illinois State Police – Crime Lab
Employer/Respondent

Case # **04** WC **13698**

Consolidated cases: **04 WC 13699, 04 WC 13700, 04 WC 13736, 06 WC 6834, 10 WC 39044**

An *Application for Adjustment 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 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. ☒ Did an accident 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 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent

On each of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**94,885.96**; the average weekly wage was $**1,824.73**.

On the dates of accident, Petitioner was **36, 40, 42, 43, 45, and 50** years old, respectively, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,216.49**/week for **9** weeks, commencing **June 4, 2008 through July 29, 2008, September 28, 2010 through October 2, 2010, February 8, 2013, and April 12, 2013**, as provided in Section 8(b) of the Act

Respondent shall be given a credit for all temporary total disability benefits that have been paid

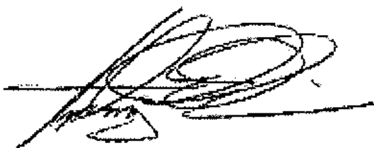
Respondent shall pay reasonable and necessary medical services of $**60,989.92**, as provided in Sections 8(a) and 8.2 of the Act

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

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **135** weeks, because the injuries sustained caused the **27%** loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

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



Arbitrator Anthony C. Erbacci

JUL 3 1 2019

July 23, 2019
Date

FACTS:

The Petitioner testified that she became employed by the Respondent as a forensic scientist on April 1, 1982 and that she continued in that employment until she retired on May 31, 2013. The Petitioner described her job duties as requiring repetitive fine motor skills and the use of a computer. Specifically, she described that she was required to cut open packages of drugs for analysis, and to input her findings into a computer. The Petitioner described that she would run tests to identify the contents of multiple items in each case, some containing up to several hundred individual pieces. These items were most often in multiple small bags or in large, wrapped packages. The Petitioner testified that she would open the items packaged in small bags using forceps and tweezers, and then sample them for testing using a spatula the thickness of a USB cord. The items packaged in large bags were often wrapped in 3-5 layers of plastic, duct tape, oil, and dryer sheets, which the Petitioner would have to cut through with an X-acto knife in order to sample and weigh the materials inside.

The Petitioner testified that she would weigh all specimens individually, take samples and place them into small glass vials the size of a fingernail, or pipette the samples using a dropper bottle. The vials the specimens were placed into needed to be crimped and uncrimped with a squeezing motion so they could be tested. The Petitioner testified that she also frequently used pliers, scissors, pens, scalpels, and X-acto knives with her right hand. The Petitioner testified that her work also involved squeezing a manual scanner to sign in evidence and carrying boxes of evidence from the evidence storage area to her workstation.

The Petitioner claims to have been injured six times during the course of her employment with the Respondent: first on January 9, 1996, then on February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Claim Number 04 WC 13698

The Petitioner testified that on January 9, 1996, she was working on a multi-item drug case that required her to open tiny bags with forceps and tweezers, sample each item with a spatula, and follow the protocol required for each case: weigh the sample, take a sample of one set using a dropper bottle for a color test, take another sample, dilute it, and place it into an instrument using a capper, and then type the information into the computer and repackage and mark every single item. The Petitioner testified that by the time she was done with this particular case, her right hand had turned purple and cold to the touch, and she had pain in her right forearm all the way up to her right shoulder and neck. The Petitioner testified that her arm was in such pain that she had difficulty pushing a door open to leave the room. The Petitioner testified that she told her direct supervisor, Sally Dillon, about the incident and her pain.

A "Supervisor's Report of Injury or Illness" was eventually completed by Sally Dillon on May 2, 1996. In this report, it is noted that on January 11, 1996 the Petitioner reported an injury on January 9, 1996 when she experienced intense pain in her right wrist area, thumb, palm and forearm while taking samples of evidence.

The Petitioner testified that she continued to work following that incident and then sought treatment from Dr. Richard Brannegan for her right shoulder, arm and hand pain. A March 27, 1996 letter report from Dr. Brannegan, addressed to Dr. John Olivieri at Meyer Medical, was admitted into

the record as Petitioner's Exhibit 4. The Arbitrator notes that no records of treatment from Dr. Olivieri were offered into evidence. In his report, Dr. Brannegan noted that the Petitioner likely had an overuse syndrome with pain in the right hand and wrist coming from local sources such as the tendons and soft tissues of the forearm. Dr. Brannegan also noted that Petitioner's work demanded a fair amount of repetitive fine hand movement which aggravated the problem. He recommended some anti-inflammatory medications, splinting of the hand, and physical therapy.

On July 9, 1996, it was noted that the Petitioner then attended 13 sessions of physical therapy for thoracic outlet syndrome at HealthSouth, which were apparently prescribed by Dr. Olivieri. On July 8, 1997, the Petitioner underwent a Functional Capacity Evaluation at Health South which indicated that Petitioner could work in the medium demand level and perform all activities of her job.

Claim Number 04 WC 13699

The Petitioner testified that on February 8, 2000, she was injured for a second time when working several multiple-item drug cases on the same day. The Petitioner testified that, for each item in each case, she would follow the same steps to test, inventory, repackage, and mark the exhibit. She testified that by the end of the day, her right hand was purple and tingling with severe pain through her wrist and arm. A "Notice of Injury" form was completed on February 22, 2000 wherein the Petitioner reported an injury to her right hand, right wrist, neck, right shoulder, and right forearm. Timely notice of this injury is not disputed.

Following the February 8, 2000 injury, the Petitioner sought treatment with Dr. William Baylis at Parkview Musculoskeletal Institute on February 29, 2000. Petitioner complained of four to five years of right-hand medial elbow pain radiating to her right side of her neck, and also noted the poor ergonomic environment of her job and her job duties. Dr. Baylis prescribed a custom forearm splint and an EMG test which was performed on March 8, 2000 and reported to be normal study. On March 16, 2000, Dr. Baylis ordered an ergonomically correct workstation for Petitioner and limited her repetitive motion to four hours out of an eight-hour workday.

The Petitioner then sought treatment with a chiropractor, Kurt James Keppner, D.C. Dr. Keppner's impression was that the Petitioner sustained a repetitive motion injury to the cervico-thoracic spine, and he recommended chiropractic care.

On November 20, 2000, the Petitioner was examined by Dr. Michael Bednar at the request of the Respondent. Dr. Bednar's impression was that Petitioner likely had a variant of thoracic outlet syndrome. He agreed with Dr. Baylis' plan for improving Petitioner's ergonomic work situation. He opined that additional physical therapy and chiropractic manipulation would not improve her condition and that she would not benefit from surgery. Dr. Bednar indicated that the Petitioner was not at a level of maximal medical improvement, and he recommended that she get an ergonomically improved workstation and continue with Dr. Baylis' restrictions of limiting repetitive work to only 50 percent of Petitioner's workday.

On April 24, 2001 Dr. Bednar noted that some ergonomic changes had been made to the Petitioner's workstation which she felt had improved some of her symptoms. On June 1, 2001Dr. Bednar noted that an MRI of the Petitioner's cervical spine had been completed and demonstrated

som mild stenosis at C6-7. Dr. Bednar then referred the Petitioner to Dr. Alexander Ghanayem at Loyola.

On June 27, 2001, the Petitioner saw Dr. Ghanayem who indicated that her MRI findings were incidental and did not correlate with her symptoms. Dr. Ghanayem did not believe that the Petitioner had a cervical spine etiology for her right upper extremity symptoms.

Claim Number 04 WC 13700

The Petitioner testified that on July 3, 2001, she was injured for a third time. The Petitioner testified that, for some time, she had been breaking up her day to avoid repetitive tasks but, on this date, she was working on a case where 14,055 grams of plant material were wrapped in layers of saran wrap, duct tape, and dryer sheets. The Petitioner testified that she cut the package open with a scalpel and X-acto knife, sampled it, and repackaged it. She testified that while repackaging the item, she experienced extreme pain in her right hand, wrist, fingers, arm, shoulder, neck and elbow.

A "Notice of Injury" form was eventually completed in which the Petitioner described an injury to her right hand which felt numb, cold, and tingly. She also reported that her right arm and right wrist area hurt the entire day and evening, and her right hand, right wrist, neck and right shoulder ached for several days. Timely notice of this injury is not disputed.

Following the July 3, 2001 injury, the Petitioner returned to Dr. Bednar at Loyola on August 14, 2001. Dr. Bednar noted that the Petitioner's symptoms were now more significant for numbness and tingling in the median nerve distribution. Dr. Bednar placed Petitioner on a 20 lbs. work restriction and discussed a future EMG test. Petitioner was also sent for biofeedback and occupational therapy which was performed at Rehabilitation Institute of Chicago. The Respondent accommodated the Petitioner's physical restrictions.

On November 13, 2001, Petitioner returned to Dr. Bednar, who noted no point tenderness, and that Petitioner could return to work without restrictions. However, Dr. Bednar also told Petitioner to change her tasks over the day and not be as repetitive. Dr. Bednar placed Petitioner at maximum medical improvement on this date.

The Petitioner then saw Dr. John Shea, a neurosurgeon at Loyola, from March to May of 2002. Dr. Shea noted right sided neck pain radiating to the right arm and hand and tingling into the right hand. Dr. Shea reviewed Petitioner's cervical MRI and did not see evidence of thoracic outlet syndrome. He allowed Petitioner to continue to work with the restrictions of Dr. Bednar.

On June 18, 2002, Dr. Bednar saw Petitioner again and his current diagnosis was pain of the neck and arms which are of undefined etiology. Dr. Bednar referred Petitioner to Dr. William Sullivan at Loyola in the physical medicine and rehabilitation department, to see if there was any further treatment available for Petitioner. Petitioner was allowed to return to work full duty without restriction on June 19, 2002. Dr. Bednar did note that the Petitioner's symptoms increased during the workday and aggravated her current condition, and that it was difficult to determine when she would reach maximum medical improvement.

On July 17, 2002, the Petitioner saw Dr. Sullivan who noted a diagnosis of chronic pain likely of myofascial origin in the shoulder and scapular regions. Dr. Sullivan showed Petitioner exercises, prescribed medications, and stated she was at maximum medical improvement. Dr. Sullivan recommended Petitioner take breaks throughout the workday.

Claim Number 04 WC 13736

The Petitioner testified that on November 25, 2003, she was injured for a fourth time. The Petitioner testified that over several days, she worked on a drug case that contained 57 small item baggies. The Petitioner testified that for each item, she was required to open the bag, weigh the specimen, mark it, write down the weight, complete preliminary testing on the color of the specimen using a dropper bottle, take another sample with the spatula, clean it off, mark the vial, add a solvent, use a pipette to decant the liquid into another vial, then crimp or screw the cap on a vial and mark it. The Petitioner testified that she needed to take frequent breaks and do her prescribed stretching throughout the project. She testified that she completed the case successfully, but experienced excruciating pain from holding the scalpels, pens, scissors, and other small and thin tools. She testified that the pain was tingling and radiated from her right thumb and wrist up to her elbow, right shoulder, and right neck. She reported the injury to her supervisor.

An "Employer's First Report of Injury" form was eventually completed and indicated a work accident of November 25, 2003 from repetitive motion while Petitioner was opening 57 bags of specimens for analysis. The report mentioned right shoulder and neck pain.

On February 6, 2004, the Petitioner sought treatment with Dr. Charles Carroll. Dr. Carroll noted a history of Petitioner's significant workload that involved multiple bags of data, wherein she developed pain in the shoulder, elbow, and hand. She complained of pain in the right neck, right chest, subclavicular region anterior shoulder, and along the course of the ulnar nerve. Dr. Carroll noted numbness and tingling in the right hand consistent with carpal tunnel syndrome. Dr. Carroll noted that there was evidence of right thoracic outlet syndrome and mild evidence of left thoracic outlet syndrome. Her neurological exam also showed evidence of ulnar neuritis and carpal tunnel syndrome. Dr. Carroll also noted possible shoulder instability. He recommended physical therapy and an MRI. He also allowed Petitioner to continue working but to not do heavy lifting and to vary her job tasks.

The Petitioner participated in physical therapy and occupational therapy at Northwestern Center for Orthopedics. She also underwent an MRI of the right shoulder on February 12, 2004 at High Tech Medical Park which was a normal study.

On February 23, 2004, Petitioner returned to Dr. Carroll who reviewed prior medical records and diagnostic studies. Dr. Carroll noted several positive physical and neurological examination findings and indicated that Petitioner had evidence of neuritis at the ulnar nerve and carpal tunnel region, even in the face of normal electrodiagnostic studies. She also had evidence of possible cervical radiculitis. Dr. Carroll recommended continued physical therapy, and an MRI of the cervical spine. He allowed Petitioner to continue working but instructed her to vary her job duties. Dr. Carroll considered Petitioner's present condition of ill-being to be aggravated by the work that she does.

Petitioner continued therapy, but with OccuSport physical therapy, throughout March and April 2004. On March 20, 2004, the Petitioner underwent a cervical MRI at High Tech Medical Park.

On May 5, 2004, Dr. Carroll noted a diagnosis of cervical spondylosis based on the March 20, 2004 MRI. Dr. Carroll recommended that Petitioner see Dr. Srdjan Mirkovic for the cervical condition and indicated that he has not yet determined that the cervical spine is the sole cause of her arm pain. Dr. Carroll noted that the Petitioner was not at maximum medical improvement but could continue working exercising care with highly repetitive activities.

Petitioner saw Dr. Mirkovic at Northwestern on June 16, 2004. Dr. Mirkovic noted complaints of neck and right arm pain radiating to the elbow and occasionally the hand with right shoulder pain. Dr. Mirkovic opined that the Petitioner's current symptoms were an aggravation of a pre-existing cervical spondylosis and he recommended a CT myelogram of the cervical spine.

The CT Myelogram was performed on August 2, 2004. Dr. Mirkovic reviewed the CT myelogram on August 17, 2004 and noted foraminal stenosis on the right at C4-5 greater than C5-6. Dr. Mirkovic noted that some of Petitioner's symptoms may be emanating from nerve root compression secondary to the foraminal stenosis. He discussed possible surgical options and recommended right C5 and C6 nerve root blocks.

On October 20, 2004, Dr. Jeff Katz performed the cervical epidural steroid injection to Petitioner's right C5-6. He noted that Petitioner's neck and shoulder felt 50 percent better after the injection. Her thumb pain was unchanged. She did not have any pain in the medial forearm, but also didn't have much pain in the forearm prior to the injection on this date. Dr. Katz noted that Petitioner could continue regular work duties but must wear an elbow pad for ulnar neuritis.

On November 9, 2004, Dr. Mirkovic noted Petitioner's benefit from cervical injection and recommended another injection. He diagnosed foraminal stenosis with radiculopathy.

Claim Number 06 WC 6834

The Petitioner testified that on November 3, 2005, she sustained a fifth injury. She testified that she had been working on a case that contained 51 items in paper bags. She had to perform the same series of steps on these items as with all the other cases, which resulted in severe pain in her right hand, right thumb, right wrist, right elbow, right shoulder, and neck. She told her supervisor on that date that she needed medical treatment. Timely notice of this injury is not disputed.

On February 17, 2006, the Petitioner returned to Dr. Carroll and complained of pain in the right elbow. Dr. Carroll diagnosed right lateral epicondylitis, cervical radiculitis, and sprains and strains of the right wrist and right hand. He ordered a new thumb Spica splint and allowed Petitioner to continue full duty work. Dr. Carroll considered the conditions work-related. Petitioner began physical therapy at OccuSport which she performed for six weeks.

The Petitioner returned to Dr. Carroll on April 14, 2006 and he noted Petitioner complained of chronic pain in the right elbow and some discomfort in the right lateral epicondyle. She also still had neck and right shoulder complaints. Dr. Carroll diagnosed triceps tendonitis and lateral epicondylitis.

Dr. Carroll referred Petitioner to Dr. Mirkovic and kept her at full duty. Petitioner continued physical therapy.

The Petitioner returned to Dr. Carroll on June 12, 2006 and he noted that her neurologic examination confirmed some epicondylitis and ulnar neuritis. Dr. Carroll recommended the Petitioner continue working, consider seeing a physiatrist, and follow up with a spine surgeon.

On August 1, 2006, Petitioner saw Dr. Mirkovic, who noted neck pain, right scapular and shoulder pain, and right arm ache. He prescribed an MRI of the cervical spine, and an EMG/NCV study of the upper extremity.

Petitioner underwent a cervical spine MRI on August 4, 2006 which showed multilevel degenerative changes. An EMG/NCV study performed on August 4, 2006 was reported to be an abnormal study indicative of chronic, mild, right C5-7 cervical polyradiculopathy without evidence of ongoing denervation. There was no electrodiagnostic evidence of a right medial mononeuropathy at the wrist or ulnar mononeuropathy.

Petitioner sought treatment with Dr. Brian Couri of the Chicago Institute of Neurosurgery and Neuroresearch on August 14, 2006. Dr. Couri's assessment included; 1) right-sided snapping scapula secondary to scapular stabilizing muscle weakness which is very prominent with significant scapular dysfunction; 2) right medial and lateral epicondylitis most likely due to overuse from the scapular dysfunction; 3) positive Hawkins' sign on the right side with right-sided impingement syndrome which is probably secondary to the scapular dysfunction with rotator cuff overuse and the weakness of the rotator cuff muscles; 4) bilateral neck pain over bilateral C2-3, C3-4, and C4-5 cervical zygapophyseal joints with left-sided osteoarthritis and right C1-2 zygapophyseal joint dysfunction, probably more secondary to the muscle imbalances but could very well be due to discomediated pain causing some pain in the cervical spine and leading to the capsular dysfunction; 5) Right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis which very well could be causing the patient to have the cervical spine pain and the shoulder pain leading to the scapular dysfunction which is the main cause of all of the rest of the patient's current symptoms; 6) Right-sided thoracic outlet syndrome, more prominent than that on the left side, which is more than likely functional in nature as opposed to any true impingement upon the thoracic outlet. It is probably more functional due to the scapular stabilizing weakness. Dr. Couri prescribed physical therapy and allowed Petitioner to continue full duty work.

Petitioner continued physical therapy at OccuSport and followed up with Dr. Couri. On October 9, 2006, Dr. Couri's assessment was a right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis; 2) right-sided functional thoracic outlet syndrome; 3) what appears to be a right very mild C5 radiculitis/radiculopathy; 4) right scapular dysfunction with shoulder impingement secondary to the C5 radiculopathy. Dr. Couri recommended a right C5 transforaminal epidural steroid injection, which was performed on October 31, 2006.

On November 7, 2006, the Petitioner was involved in an unrelated motor vehicle accident. The Petitioner testified that she was hit while making a U-turn and suffered *left* upper trapezius muscle pain and *left-sided* neck pain, neither of which exacerbated the right-sided neck pain she was experiencing from her work injury. The Petitioner testified that there was no injury to her right upper extremity in this automobile accident.

On November 13, 2006, Petitioner attended physical therapy with OccuSport and the therapist noted that Petitioner's recent motor vehicle accident affected the left upper trapezius and had no effect on the work-related right side. It was noted that the Petitioner reported an overall improvement in her right-sided symptoms since her epidural injection on October 31, 2006. On November 14, 2006 Dr. Couri noted that the motor vehicle accident caused left scapular/shoulder-area spasms and increased left sided neck pain, but that her right-sided neck pain did not become any worse. He allowed Petitioner to continue working full duty.

Dr. Couri performed additional injections to the right C2-3, C5-6, and C6-7 zygapophyseal joints on December 19, 2006. Petitioner continued therapy.

On February 2, 2007, Petitioner saw Dr. Couri again and he recommended that Petitioner continue full time work but to do one-third less cases, and to instead spend that time doing something like teaching which she had done in the past. Dr. Couri ordered another EMG/NCV test of the right arm and an elbow injection.

An MRI arthrogram of the Petitioner's right shoulder was performed on June 14, 2007 at Future Diagnostics Group and was reported to be unremarkable.

The Petitioner was then referred by Dr. Couri to Dr. Giridhar Burra at Hinsdale Orthopedic Associates on June 22, 2017. Dr. Burra noted several positive physical exam findings relative to the right shoulder. Dr. Burra reviewed diagnostics and made a diagnosis of biceps tendinitis and a possible superior labrum anterior and posterior lesion. Dr. Burra recommended a diagnostic right shoulder arthroscopy.

On July 16, 2007, Petitioner returned to Dr. Couri who agreed with Dr. Burra's plan of diagnostic right shoulder arthroscopy. Dr. Couri stated that "it appears all of her symptoms came about with chronic repetitive work and lifting of heavy objects, and I believe that her right shoulder is the main cause of her symptoms which has exacerbated the neck and now the elbow." Dr. Couri placed Petitioner on 10 lbs. lifting restrictions and no overhead work.

On August 1, 2007, Petitioner was involved in another unrelated motor vehicle accident. She was taken to Silver Cross Hospital and complained of a left upper arm abrasion, a right shoulder abrasion, and mid lower back pain. The Petitioner testified that she only experienced slight soreness on her left side as a result of this accident.

On September 21, 2007, Dr. Burra authored a letter indicating that Petitioner's right shoulder/bicep symptoms preceded the motor vehicle accident and that she never had relief of symptoms prior to the motor vehicle accident. Accordingly, Dr. Burra opined that her shoulder symptoms were primarily related to her work injury and did not believe that the motor vehicle accident caused the injury.

On June 4, 2008, the Petitioner underwent right shoulder surgery at Silver Cross Hospital with Dr. Burra. The post-operative diagnosis was a SLAP lesion, subacromial bursitis and mild impingement in the right shoulder. The procedure consisted of right shoulder arthroscopy, SLAP lesion repair and subacromial decompression. Following surgery, Petitioner continued following up with Dr. Burra and performing physical therapy.

On November 19, 2008, the Petitioner reported to Dr. Burra that her right shoulder was doing well with increasing motion. However, she had a complaint on this date of rather extreme exacerbation of left elbow epicondylitis. She was diagnosed with left lateral epicondylitis. Dr. Burra recommended therapy for both the right shoulder and left elbow, and to remain restricted at work.

On January 7, 2009, Dr. Burra noted that Petitioner had made great progress with the right shoulder and could discontinue therapy and progress to a home exercise program. Dr. Burra placed Petitioner on restrictions for the right shoulder of no lifting greater than 25 lbs. and recheck in 6 weeks. Relative to the left elbow, Petitioner still complained of left elbow pain, worse with any gripping or lifting. Dr. Burra recommended a cortisone injection and continuation of physical therapy. The injection was done on this date. Dr. Burra also placed restrictions of no gripping with the left arm.

On April 17, 2009, Dr. Burra noted that Petitioner was pretty much asymptomatic for the right shoulder. He placed Petitioner at maximum medical improvement for her right shoulder and allowed her to return to full duty without restriction. However, for her continued right elbow symptoms, Dr. Burra noted that Petitioner had previous complaints suggestive of ulnar neuritis. He also noted that people with shoulder surgeries are at a higher risk because of the significant amount of flexion with performance of the rehab and immobilization after shoulder surgery, and this would put this condition for an exacerbation. He diagnosed ulnar nerve neuropathy and recommended a night splint. For the left elbow, Dr. Burra performed another injection and discussed possible surgical intervention if not improved. She was returned back to work with restrictions of no gripping with the left hand.

On June 25, 2009, the Petitioner saw Dr. Burra and reported that she was symptomatic in regard to her right elbow, complaining of paresthesia to the right ulnar nerve distribution. She was also tender over the left lateral epicondyle in the left elbow. Dr. Burra stated that "her right shoulder pathology [was] related causally to her right elbow symptoms..." For the left elbow lateral epicondylitis, he stated it is not a traumatic condition but an overuse syndrome. Dr. Burra discussed surgical options and recommended an MRI of the left elbow. A left elbow MRI was performed on July 9, 2009 at Future Diagnostics Group.

Dr. Burra reviewed the MRI of the left elbow on July 29, 2009 and diagnosed left epicondylitis. However, Petitioner reported improvement in her symptoms, and wanted to defer any surgical intervention unless symptoms worsen. Dr. Burra allowed her to continue to work with limitations of no repetitive gripping in the left hand, and to follow-up as needed.

On August 1, 2009, the Petitioner returned to Dr. Mirkovic for neck and right shoulder pain, and he ordered an MRI of the cervical spine and an EMG/NCV of the right upper extremity.

The Petitioner returned to Dr. Burra on December 2, 2009 complaining of increased right shoulder pain that freezes, cracks and pops, as well as increased pain with overhead activities or reaching behind or across her body. Dr. Burra diagnosed right elbow lateral epicondylitis as well as cubital tunnel syndrome. He recommended a repeat MRI arthrogram, and also to return after the EMG was done relative to the right elbow.

The Petitioner returned to Dr. Burra on January 6, 2010. Despite a negative EMG, Dr. Burra felt that the Petitioner had left elbow cubital tunnel syndrome and recommended ulnar nerve transposition surgery. For the right elbow, he diagnosed lateral epicondylitis, and recommended conservative treatment. Relative to the right shoulder, the MRI arthrogram showed some post-

surgical changes, but Dr. Burra recommended trying to manage it conservatively. The Petitioner was kept on restrictions of no repetitive gripping and no lifting greater than 5 lbs.

On July 2, 2010, the Petitioner had another EMG with Dr. Wayne Kelly of Health Benefits Pain Management. The EMG was noted to be abnormal, and the impression was 1) a right-sided chronic underlying chronic C6-7 cervical radiculopathy with evidence of primarily chronic axonal involvement; 2) a superimposed right-sided mild chronic compression/entrapment ulnar neuropathy across the elbow (Cubital tunnel syndrome) with evidence of mild focal demyelination and mild chronic axonal involvement, likely indicative of a double crush injury; 3) a bilateral moderate chronic compression/entrapment median mono neuropathies at the wrist (carpal tunnel syndrome) with evidence of moderate focal demyelination of both sensory and motor nerves as well as chronic axonal involvement; 4) no electrophysiological evidence of an underlying sensory/motor polyneuropathy or right brachial plexopathy. Dr. Kelly recommended two C6-7 cervical injections, a right ulnar nerve steroid block along the ulnar nerve, and a right distal medial nerve steroid block at the carpal tunnel and use of cock-up wrist splints.

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The Petitioner testified that on August 2, 2010, she was injured for a sixth time when working on a case with several kilos of plant material wrapped in multiple layers of saran wrap. The Petitioner testified that she was using an X-acto knife to cut open the packages and enter the information into the computer. By the time she was done analyzing, sampling, and repackaging, her right and left hands, wrists, and thumbs were in significant pain.

The Petitioner reported the incident to her supervisor and an accident report was eventually completed. The Petitioner reported in the accident report that she was opening packaged kilos of cannabis. She had to cut open the package and remove the cannabis for weight and analysis. During these job duties, she felt pain in her right wrist, right elbow, left wrist, and bilateral hands. Timely notice of this injury is not disputed.

On August 16, 2010, the Petitioner returned to Dr. Burra, and she reported that her right shoulder pain was significantly resolved, and her left elbow pain was improved. She complained, however, that she was very limited and affected by her right elbow pain. She reported the recent work activity of opening multiple kilo packs which involved significant flexion/extension across her right elbow and had worsened her symptoms. Dr. Burra reviewed the EMG from July 2010. Dr. Burra indicated that Petitioner had a double crush condition. Dr. Burra recommended ulnar nerve transposition surgery.

Surgery was performed on September 28, 2010 to the right elbow. The pre-and-post operative diagnosis was ulnar nerve compression neuropathy of the right elbow. The procedure performed consisted of right-side ulnar nerve anterior transposition with a subcutaneous technique. Petitioner was placed on sedentary work/paperwork only duties.

Petitioner continued following-up with Dr. Couri in 2010 and did physical therapy for the post-operative right elbow.

On November 17, 2010, Dr. Burra recorded that Petitioner's numbness and tingling in her right 4th and 5th fingers was resolving post-surgery. Her left elbow was asymptomatic as of this date. Dr. Burra placed Petitioner on continued work restrictions.

On December 28, 2010, Dr. Burra noted that the Petitioner's right 4th and 5th finger symptoms had resolved. Her right elbow was doing much better. Noting that the Petitioner's right elbow, right shoulder, and left elbow symptoms were under control, Dr. Burra released her from his care. Dr. Bura indicated that the Petitioner was able to return to work relative to the right elbow, right shoulder and left elbow, but he noted that the Petitioner was still treating with Dr. Couri for carpal tunnel syndrome.

The Petitioner continued treatment with Dr. Couri in early 2011 for bilateral carpal tunnel syndrome. On January 10, 2011, she complained of bilateral hand symptoms which were improving. She still had a complaint of left elbow pain at this visit and she reported that her work aggravated both conditions. Dr. Couri kept Petitioner on work restrictions.

On March 25, 2011, Dr. Couri performed a left eblow lateral epicondyle injection, and instructed Petitioner to continue using a cock-up wrist splint. She was kept on work restrictions. On April 19, 2011, Dr. Couri recommended another cervical MRI, and kept Petitioner on work restrictions.

On May 23, 2011, Dr. Couri reviewed the April 26, 2011 MRI. Petitioner reported doing better with the left elbow pain since the injection. She was still having mild left lateral elbow pain and left sided neck pain. Dr. Couri recommended left C6 and C7 transforaminal epidural steroid injections and physical therapy, which Petitioner wanted to defer for the time being. She would instead try a home traction unit for one to two weeks first. She was kept on work restrictions. Dr. Couri performed an additional left elbow injection on August 2, 2011.

The Petitioner continued following up with Dr. Couri in 2012. By October 1, 2012, Dr. Couri noted that Petitioner had bilateral wrist pain and weakness. She reported numbness and tingling with fine motor activities, and also decreased grip. Dr. Couri's diagnoses was bilateral moderate carpal tunnel syndrome. He discussed bilateral percutaneous carpal tunnel release surgery in the future. She was kept on work restrictions.

On October 26, 2012, Petitioner underwent bilateral *percutaneous* carpal tunnel release surgeries with Dr. Couri.

She returned to Dr. Couri on December 6, 2012 who noted that the carpal tunnel releases had failed. He referred the Petitioner to Dr. John Fernandez at Midwest Orthopedics at Rush for another opinion.

The Petitioner saw Dr. Fernandez for the first time on January 9, 2013, and he diagnosed the Petitioner with bilateral carpal tunnel syndrome, bilateral thumb CMC joint osteoarthritis, and bilateral upper extremity pain. He recommended bilateral carpal tunnel release procedures.

On February 8, 2013, Petitioner underwent left wrist carpal tunnel release with Dr. John Fernandez. On February 25, 2013, Dr. Fernandez noted that Petitioner's paresthesias in the left hand had nearly completely resolved.

On April 12, 2013, Petitioner underwent right wrist carpal tunnel release surgery with Dr. Fernandez. Petitioner saw Dr. Fernandez on April 29, 2013, who noted improvement after right wrist surgery relative to numbness and tingling. Her main complaint on this day was pillar pain primarily worse on the right than left, worse with direct pressure of the palm and also worse with lifting activities. Dr. Fernandez noted that Petitioner could work with restrictions until June 1, 2013 at which time she would be at maximum medical improvement and able to return to full duty work.

The Petitioner testified that she lost one day of work for each carpal tunnel surgery and that the Respondent continued to accommodate her restrictions. She testified that she did less repetitive work and she participated in more teaching activities at work.

The Petitioner continued to work on restricted duty until May 31, 2013 when she voluntarily retired from her employment with the State of Illinois.

On May 27, 2015, the Petitioner returned to Dr. Fernandez with complaints of a bump/nodule on her left palm which was slightly tender to palpation and bothered her when performing gripping and working out activities. Relative to the right upper extremity, she complained of volar wrist pain. Her neurologic complaints from the median nerve distribution were completely resolved at this point. Dr. Fernandez performed a physical exam which noted a slight thickening of the surgical site along the left palm, and also a Dupuytren's nodule associated with the middle finger of the left palm. Relative to the right wrist, she had very minimal swelling along the volar aspect. She had full range of motion of the hand, wrist, and elbow. X-rays were performed which revealed ulnar positive variance by approximately 2mm. Dr. Fernandez' diagnoses were 1) left hand Dupuytren's disease, nodular phase; 2) bilateral upper extremity pain beginning while working as a chemist in 2012. Some medications were prescribed, and she was told to follow-up as needed.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

The Petitioner was examined at the request of her attorney by Dr. Samuel Chmell on October 15, 2015. Dr. Chmell's deposition testimony was admitted into the record as Petitioner's Exhibit 20. Dr. Chmell testified as to his understanding of the Petitioner's job duties and work history as well as her history of injuries and his examination findings. Dr. Chmell made the following seven diagnoses for the Petitioner: 1) bilateral carpal tunnel syndrome and multiple tendinitis, both wrists status post bilateral carpal tunnel releases times two; 2) right elbow cubital tunnel syndrome, status post ulnar nerve decompression and anterior transposition; 3) right shoulder SLAP lesion and impingement

syndrome, status post arthroscopy SLAP repair and subacromial decompression; 4) right shoulder snapping scapula syndrome; 5) bilateral elbow lateral and medial epicondylitis; 6) traumatic aggravation of degenerative disc disease in cervical spine with right upper extremity radiculopathy; and 7) right thoracic outlet syndrome.

Relative to causation, Dr. Chmell testified as to each of his seven diagnoses:

Relative to the bilateral carpal tunnel syndrome/multiple tendonitis hands and wrist, status post bilateral carpal tunnel release times two, Dr. Chmell testified that these conditions are causally related to Petitioner's work accidents of January 9, 1996, February 8, 2000, July 3, 2001, and August 2, 2010. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right cubital tunnel syndrome, status post ulnar nerve decompression and anterior decompression and interior transposition, Dr. Chmell testified that this condition was causally related to the July 3, 2001 and the August 2, 2010 work accidents. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right shoulder SLAP lesion and impingement syndrome status post arthroscopy, SLAP repair and subacromial decompression, Dr. Chmell testified that this condition was causally related to the work accident of November 25, 2003, which was aggravated on November 3, 2005. Dr. Chmell testified that this injury was a result of Petitioner's repetitive activities at work and that all treatment for those conditions to date has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right shoulder snapping scapular syndrome, Dr. Chmell testified that this condition is causally related to the November 25, 2003 work accident which was later aggravated during the November 3, 2005 work accident. Dr. Chmell testified that all treatment for this condition was reasonable, necessary, and causally related to the work accidents.

Relative to the diagnosis of bilateral elbow lateral and medial epicondylitis, Dr. Chmell testified that the right arm condition was causally related to the July 3, 2001 work accident and was further aggravated by the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell testified that the left elbow condition became involved after the August 2, 2010 work accident. Dr. Chmell opined that all treatment to date for these conditions has been reasonable, necessary, and related to the work accidents.

Relative to the diagnosis of cervical spinal traumatic aggravation of degenerative disc disease with right upper extremity radiculopathy, Dr. Chmell testified that this condition was causally related to the work accident of February 8, 2000, and further aggravated by the July 3, 2001, November 3, 2005, and August 2, 2010 work accidents. The condition was confirmed by positive EMG findings following the November 3, 2005 work accident. Dr. Chmell opined that all treatment to date for this condition has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right thoracic outlet syndrome, Dr. Chmell testified that this condition was causally related to the February 8, 2000 work accident, which was later aggravated during the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell opined that all

treatment for this condition to date has been reasonable, necessary, and related to the work accidents.

Dr. Chmell reviewed several accident reports which were included in Petitioner's Deposition Exhibit #4 at the deposition and noted that Petitioner's job duties as described in the reports are consistent with the type of activity that could cause the conditions he diagnosed.

Dr. Chmell opined that as of the date he saw Petitioner on October 15, 2015, Petitioner was at maximum medical improvement. Dr. Chmell also opined that Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma. Finally, Dr. Chmell testified that Petitioner's work restrictions in this case have been related to her work injuries.

Dr. Chmell testified that he disagreed with Dr. Verma's conclusion that the Petitioner's work was not consistent with a mechanism to cause A-C joint arthrosis or biceps tendon superior labral tearing. Dr. Chmell opined that repetitive motion activities can affect the shoulder when the labrum is stressed and eventually shreds and tears. Dr. Chmell further disagreed with Dr. Verma's conclusion that Petitioner reached MMI on March 17, 2008. Dr. Chmell disagreed because he believed Petitioner's shoulder surgery on June 4, 2008 helped her condition.

At the request of the Respondent, the Petitioner was examined by Dr. Nikhil Verma on March 17, 2008 and April 17, 2017 and he performed a record review on January 10, 2018. Dr. Verma's April 4, 2018 deposition testimony was admitted into the record as Respondent's Exhibit 20.

With regard to his examination of the Petitioner on March 17, 2008, Dr. Verma testified that he examined the Petitioner and reviewed the Petitioner's medical records from 2002 through 2007. Dr. Verma testified that he didn't review a written description of the Petitioner's job duties in preparation for the exam but the Petitioner described to him that her work as a forensic scientist involved using her hands for fine work, including opening small packages and testing substances and powders. Dr. Verma's diagnosis was right upper extremity pain with possible cervical spondylosis and radiculopathy. Dr. Verma did not believe this to be causally related to her job duties, because he did not locate a diagnosis within the shoulder that would be responsible for her symptoms, which he viewed to be diffuse in nature and not explained by the Petitioner's AC joint, biceps, or SLAP problems. Dr. Verma further testified that a repetitive use type mechanism is not consistent with a SLAP pathology in an individual of the Petitioner's age group.

Dr. Verma stated that degenerative changes in the labrum are common for patients in Petitioner's age group, and that the only repetitive use mechanism that generates SLAP tears is throwing a baseball at 80-plus miles per hour, which is not an activity in which he believed Petitioner was participating. Dr. Verma stated that repetitive work would be similarly inconsistent with superior labral pathology. Dr. Verma did not believe that the Petitioner's clinical exam findings supported the diagnosis of superior labral pathology, given their diffuse nature involving multiple components of her upper extremity.

Dr. Verma opined that Petitioner did not require any additional medical treatment for her shoulder related to a work injury, did not require any work restrictions, and was at maximum medical improvement.

With regard to his examination of the Petitioner on March 17, 2017, Dr. Verma testified that he reviewed the Petitioner's medical records from Dr. Burra, pain management records, records from Hinsdale Orthopedics, and records from Dr. Chmell. Dr. Verma noted that Petitioner's bilateral shoulders were normal aside from healed incisions on the right side and he indicated that the Petitioner demonstrated full range of motion, normal cervical motion, normal neurovascular systems, and no provocative testing findings on either shoulder. Dr. Verma opined that the Petitioner's right shoulder was essentially normal both objectively and subjectively. She had undergone right shoulder SLAP repair, which Dr. Verma did not believe was causally related to the work activities. Dr. Verma also opined that Petitioner was at maximum medical improvement for the shoulders, that no additional treatment was needed, and that she did not require any work restrictions relative to the shoulders.

With regard to his review of additional medical records of the Petitioner's treatment from 1996 through 2010, Dr. Verma testified that he also reviewed a job description in conjunction with authoring this report. Following his review of the updated records, Dr. Verma diagnosed the Petitioner with chronic upper extremity pain with possible fibromyalgia-type symptoms. Dr. Verma again stated that he did not believe Petitioner's condition to be causally related to her job duties.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

After reviewing all testimony and evidence, the Arbitrator hereby finds that the Petitioner did sustain accidents that arose out of and in the course of her employment by the Respondent on January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010. The accidents are supported by the Petitioner's testimony and corroborated by the accident reports and the treating medical records.

The respondent did not call any witnesses to dispute the Petitioner's version of her job duties or how the accidents occurred.

With regard to the issue of Notice, the Arbitrator notes that the Respondent only disputed the issue of timely notice with regard to the initial injury of January 9, 1996 (Claim Number 04 WC 13698). Based upon the Petitioner's unrebutted testimony, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Several of Petitioner's treating physicians provided opinions as to causation in this case over the years.

On March 27, 1996, while referring to Petitioner's soft tissue/tendons in the right forearm, Dr. Brannegan noted that "it sounds as if [Petitioner's] work demands a fair amount of repetitive fine hand movement, and this probably aggravates this problem."

Dr. Bayliss indicated in February and March of 2000 that Petitioner's symptoms are related to the ergonomics of her workstation and recommended altering the workstation.

Kurt James Keppner, D.C. noted on April 28, 2000 that Petitioner's condition has deteriorated over the last four months caused by her overuse at an ergonomically unsound workstation that places undue stress and strain on her neck and upper back.

On May 30, 2002, Dr. Shea at Loyola noted that "working aggravates all of her symptoms" while discussing Petitioner's neck, right arm, right thumb and grip strength.

On June 18, 2002, Dr. Bednar noted "I believe the work that she does aggravates her current condition." He also ordered her workstation be modified.

On February 6, 2004, Dr. Charles Carroll at Northwestern noted "[Petitioner] has an ongoing problem which has been further aggravated by her more recent work stress" while discussing a possible diagnosis of neuritis of the upper extremity. On February 26, 2004, Dr. Carroll stated, "I have considered her present condition of ill-being to be aggravated by the work that she discussed in previous correspondence."

Dr. Burra at Hinsdale Orthopedics stated on August 16, 2001 that "while the shoulder per se does not cause her ulnar nerve symptoms at the elbow... I have seen incidence or worsening of cubital tunnel syndrome following shoulder surgery because of the degree and duration of flexion that is required across the elbow both in the immediate postoperative period while she is in the sling as well as during the course of rehabilitative exercise and physical therapy following shoulder surgery, and I have seen this in my practice where there is an aggravation of this. As such, there is some relationship between her shoulder surgery and her elbow symptoms."

Dr. Burra also opined as to causation for the right shoulder SLAP lesion and biceps tendinitis in his September 21, 2007 correspondence. In this note, Dr. Burra opined that there is a clear-cut causal relationship of the work injury of November 3, 2005 to the right shoulder condition. He ruled out the auto accident as a cause of her condition.

Dr. Samuel Chmell, who examined the Petitioner at her attorney's request, testified that the sum of all the Petitioner's job duties involved repetitive stressful and difficult movements of Petitioner's upper extremities, right greater than left. He testified that the Petitioner did these tasks for 32 years, which was significant because her job duties subjected her upper extremities to repetitive motion activities, which is akin to overuse activities. Dr. Chmell testified that the Petitioner's job duties are consistent with the type of activity that could cause the conditions diagnosed in this case.

Dr. Chmell found seven diagnoses, which he opined were causally related to one or more of the work accidents in this case. Dr. Chmell noted that the Petitioner did not have any problems with her neck or upper extremities prior to working as a forensic chemist for the Respondent. Dr. Chmell

opined that the following seven diagnosed conditions were causally related to the Petitioner's work accidents:

1) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Nikhil Verma, the Respondent's examining physician, opined that Petitioner's diagnosis was chronic upper extremity pain with possible fibromyalgia-type symptoms. He did not feel that these conditions were causally related to her job duties. Dr. Verma only evaluated Petitioner relative to her bilateral shoulders and he did not evaluate her for any other body parts or conditions.

After reviewing all of the medical records, testimony and evidence, the Arbitrator finds the causation opinions of Petitioner's treating doctors to be consistent with the evidence and persuasive. The opinions and testimony of Dr. Samuel Chmell are credible and well-founded. Dr. Chmell's opinions correlate with those of Petitioner's treating doctors. Dr. Chmell also understood Petitioner's job duties consistent with Petitioner's testimony. While the Arbitrator notes the findings and opinions of Dr. Verma, the Arbitrator finds the causation opinions of the Petitioner's treating physicians, including Drs. Brannnegan, Carroll, Bayliss, Keppner, Shea, and Bednar to be persuasive. The Arbitrator also finds the opinions of Dr. Sam Chmell to be sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's work injuries on January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

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:

At trial, Petitioner submitted evidence of unpaid medical bills totaling $58,148.92, as summarized in Petitioner's Exhibit 31. Dr. Chmell testified that all medical treatment rendered to the Petitioner for her diagnosed conditions was reasonable, necessary, and causally related to the work accidents in this case. The Arbitrator hereby adopts the opinions of Dr. Chmell, which are sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof and finds that the unpaid medical bills totaling $58,148.92 set forth in Petitioner's Exhibit 31 are reasonable, necessary, and causally related to the work accidents of January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Additionally, the Petitioner submitted evidence of out-of-pocket travel/mileage costs as summarized in Petitioner's Exhibit 31. Section 8(a) of the Act states that the employer shall pay for treatment, vocational rehabilitation, and all services reasonably required to cure or relieve the effects

of the accidental injury. 820 ILCS 305(8)(a). Travel expenses are awarded in cases where it was reasonably necessary for the petitioner to travel in order to receive medical treatment. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). Here, the Petitioner's travel for treatment from 1996 through 2012 was for physical therapy, doctor's appointments, and testing, which all constitute reasonable travel expenses under the law. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate.

The Petitioner's mileage for travel to and from medical appointments as submitted in Petitioner's Exhibit 31 totals 17,629 miles. Applying the appropriate "IRS medical" rate applicable at the time of the travel, results in the total amount of $2,841.00 due. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate in the amount of $2,841.00.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she underwent surgery to her right shoulder on June 4, 2008 and that she was off work as a result of that surgery through July 29, 2008, a period of 8 weeks. The Petitioner testified that she underwent surgery to her right elbow on September 28, 2010 and that she was off work as a result of that surgery through October 2, 2010, a period of 5/7 weeks. The Petitioner underwent surgery to her left and right hands on February 8, 2013 and April 12, 2013, respectively, and that she was off work for one day after each of those surgeries, a period of 2/7 weeks. Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits for the periods of June 4, 2008 through July 29, 2008, a period of 8 weeks, September 28, 2010 through October 2, 2010, a period of 5/7 weeks, February 8, 2013, a period of 1/7 weeks, and April 12, 2013, a period of 1/7 weeks.

While the Petitioner claimed to be entitled to Temporary Partial Disability benefits for the hours of work that she missed obtaining treatment and therapy, the Arbitrator finds that the Petitioner failed to provide sufficient specific evidence of the actual periods of disability to allow the calculation of the exact amount of Temporary Partial Disability benefits that may be due, if any. The Arbitrator finds, therefore, that the Petitioner failed to meet its burden of proof with regard to what Temporary Partial Disability benefits, if any, are due. Accordingly, no Temporary Partial Disability benefits are awarded herein.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that Dr. Fernandez, the last physician who treated the Petitioner, noted that the Petitioner would be at maximum medical improvement by June 1, 2013 at which time she would be able to return to full duty work.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into

the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

Dr. Chmell, who examined the Petitioner at the request of her attorney on October 15, 2015, found seven diagnoses, which he opined were causally related to one or more of the Petitioner's work accidents:

2) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Chmell opined that the Petitioner was at maximum medical improvement. Dr. Chmell also opined that the Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a cumulative result of the Petitioner's six work injuries the Petitioner sustained permanent partial disability to her whole person to the extent of 27% thereof.

In Support of the Arbitrator's Decision relating to (N.), Is Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent claimed a credit under Section 8(j) of $17,894.58 (04WC13699); $3,955.04 (04WC13736); $33,044.57 (06WC6834). Respondent entered exhibits #13, 14, and 15 in support of their alleged 8(j) credit. Petitioner disputed the Respondent's entitlement to an 8(j) credit at the time of arbitration.

However, after the hearing on June 4, 2019, the parties entered into a stipulation on June 5, 2019 wherein they agreed that "the payments made by the Respondent referred to and contained in Respondent's exhibits 13, 14, and 15 were made by the workers' compensation claims department who administers, pays, and adjusts workers' compensation claims for the State of Illinois. The State

of Illinois is a self-insured employer under the Illinois Workers' Compensation Act. They are not payments made by a group insurance carrier."

The Arbitrator finds that the Respondent is entitled to credit for all of the 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	04WC013700
Case Name	RIZO, AURELIA L v. IL ST POLICE CRIME LAB
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0210
Number of Pages of Decision	25
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Danielle Curtiss

DATE FILED: 4/21/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aurelia Rizo,

Petitioner,

vs. NO: 04 WC 13700

Illinois State Police – Crime Lab,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 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, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: **4/21/2021**

MP:yl
o 4/15/21
68

/s/ *Marc Parker*

/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIZO, AURELIA
Employee/Petitioner

Case# **04WC013698**

04WC013699
04WC013700
04WC013736
06WC006834
10WC039044

ILLINOIS STATE POLICE-CRIME LAB
Employer/Respondent

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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
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

JUL 31 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aurelia Rizo
Employee/Petitioner

v.

Illinois State Police – Crime Lab
Employer/Respondent

Case # **04** WC **13698**

Consolidated cases: **04 WC 13699, 04 WC 13700, 04 WC 13736, 06 WC 6834, 10 WC 39044**

An *Application for Adjustment 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 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. [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 [ ] Maintenance [x] TTD

L. [x] What is the nature and extent of the injury?

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

N. [x] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On **January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent

On each of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**94,885.96**; the average weekly wage was $**1,824.73**.

On the dates of accident, Petitioner was **36, 40, 42, 43, 45, and 50** years old, respectively, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,216.49**/week for **9** weeks, commencing **June 4, 2008 through July 29, 2008, September 28, 2010 through October 2, 2010, February 8, 2013, and April 12, 2013**, as provided in Section 8(b) of the Act

Respondent shall be given a credit for all temporary total disability benefits that have been paid

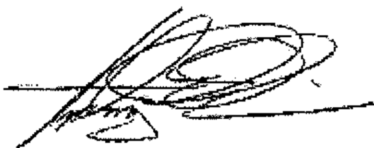
Respondent shall pay reasonable and necessary medical services of $**60,989.92**, as provided in Sections 8(a) and 8.2 of the Act

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

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **135** weeks, because the injuries sustained caused the **27%** loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

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



Arbitrator Anthony C. Erbacci

JUL 3 1 2019

July 23, 2019
Date

FACTS:

The Petitioner testified that she became employed by the Respondent as a forensic scientist on April 1, 1982 and that she continued in that employment until she retired on May 31, 2013. The Petitioner described her job duties as requiring repetitive fine motor skills and the use of a computer. Specifically, she described that she was required to cut open packages of drugs for analysis, and to input her findings into a computer. The Petitioner described that she would run tests to identify the contents of multiple items in each case, some containing up to several hundred individual pieces. These items were most often in multiple small bags or in large, wrapped packages. The Petitioner testified that she would open the items packaged in small bags using forceps and tweezers, and then sample them for testing using a spatula the thickness of a USB cord. The items packaged in large bags were often wrapped in 3-5 layers of plastic, duct tape, oil, and dryer sheets, which the Petitioner would have to cut through with an X-acto knife in order to sample and weigh the materials inside.

The Petitioner testified that she would weigh all specimens individually, take samples and place them into small glass vials the size of a fingernail, or pipette the samples using a dropper bottle. The vials the specimens were placed into needed to be crimped and uncrimped with a squeezing motion so they could be tested. The Petitioner testified that she also frequently used pliers, scissors, pens, scalpels, and X-acto knives with her right hand. The Petitioner testified that her work also involved squeezing a manual scanner to sign in evidence and carrying boxes of evidence from the evidence storage area to her workstation.

The Petitioner claims to have been injured six times during the course of her employment with the Respondent: first on January 9, 1996, then on February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Claim Number 04 WC 13698

The Petitioner testified that on January 9, 1996, she was working on a multi-item drug case that required her to open tiny bags with forceps and tweezers, sample each item with a spatula, and follow the protocol required for each case: weigh the sample, take a sample of one set using a dropper bottle for a color test, take another sample, dilute it, and place it into an instrument using a capper, and then type the information into the computer and repackage and mark every single item. The Petitioner testified that by the time she was done with this particular case, her right hand had turned purple and cold to the touch, and she had pain in her right forearm all the way up to her right shoulder and neck. The Petitioner testified that her arm was in such pain that she had difficulty pushing a door open to leave the room. The Petitioner testified that she told her direct supervisor, Sally Dillon, about the incident and her pain.

A "Supervisor's Report of Injury or Illness" was eventually completed by Sally Dillon on May 2, 1996. In this report, it is noted that on January 11, 1996 the Petitioner reported an injury on January 9, 1996 when she experienced intense pain in her right wrist area, thumb, palm and forearm while taking samples of evidence.

The Petitioner testified that she continued to work following that incident and then sought treatment from Dr. Richard Brannegan for her right shoulder, arm and hand pain. A March 27, 1996 letter report from Dr. Brannegan, addressed to Dr. John Olivieri at Meyer Medical, was admitted into

the record as Petitioner's Exhibit 4. The Arbitrator notes that no records of treatment from Dr. Olivieri were offered into evidence. In his report, Dr. Brannegan noted that the Petitioner likely had an overuse syndrome with pain in the right hand and wrist coming from local sources such as the tendons and soft tissues of the forearm. Dr. Brannegan also noted that Petitioner's work demanded a fair amount of repetitive fine hand movement which aggravated the problem. He recommended some anti-inflammatory medications, splinting of the hand, and physical therapy.

On July 9, 1996, it was noted that the Petitioner then attended 13 sessions of physical therapy for thoracic outlet syndrome at HealthSouth, which were apparently prescribed by Dr. Olivieri. On July 8, 1997, the Petitioner underwent a Functional Capacity Evaluation at Health South which indicated that Petitioner could work in the medium demand level and perform all activities of her job.

Claim Number 04 WC 13699

The Petitioner testified that on February 8, 2000, she was injured for a second time when working several multiple-item drug cases on the same day. The Petitioner testified that, for each item in each case, she would follow the same steps to test, inventory, repackage, and mark the exhibit. She testified that by the end of the day, her right hand was purple and tingling with severe pain through her wrist and arm. A "Notice of Injury" form was completed on February 22, 2000 wherein the Petitioner reported an injury to her right hand, right wrist, neck, right shoulder, and right forearm. Timely notice of this injury is not disputed.

Following the February 8, 2000 injury, the Petitioner sought treatment with Dr. William Baylis at Parkview Musculoskeletal Institute on February 29, 2000. Petitioner complained of four to five years of right-hand medial elbow pain radiating to her right side of her neck, and also noted the poor ergonomic environment of her job and her job duties. Dr. Baylis prescribed a custom forearm splint and an EMG test which was performed on March 8, 2000 and reported to be normal study. On March 16, 2000, Dr. Baylis ordered an ergonomically correct workstation for Petitioner and limited her repetitive motion to four hours out of an eight-hour workday.

The Petitioner then sought treatment with a chiropractor, Kurt James Keppner, D.C. Dr. Keppner's impression was that the Petitioner sustained a repetitive motion injury to the cervico-thoracic spine, and he recommended chiropractic care.

On November 20, 2000, the Petitioner was examined by Dr. Michael Bednar at the request of the Respondent. Dr. Bednar's impression was that Petitioner likely had a variant of thoracic outlet syndrome. He agreed with Dr. Baylis' plan for improving Petitioner's ergonomic work situation. He opined that additional physical therapy and chiropractic manipulation would not improve her condition and that she would not benefit from surgery. Dr. Bednar indicated that the Petitioner was not at a level of maximal medical improvement, and he recommended that she get an ergonomically improved workstation and continue with Dr. Baylis' restrictions of limiting repetitive work to only 50 percent of Petitioner's workday.

On April 24, 2001 Dr. Bednar noted that some ergonomic changes had been made to the Petitioner's workstation which she felt had improved some of her symptoms. On June 1, 2001Dr. Bednar noted that an MRI of the Petitioner's cervical spine had been completed and demonstrated

som mild stenosis at C6-7. Dr. Bednar then referred the Petitioner to Dr. Alexander Ghanayem at Loyola.

On June 27, 2001, the Petitioner saw Dr. Ghanayem who indicated that her MRI findings were incidental and did not correlate with her symptoms. Dr. Ghanayem did not believe that the Petitioner had a cervical spine etiology for her right upper extremity symptoms.

Claim Number 04 WC 13700

The Petitioner testified that on July 3, 2001, she was injured for a third time. The Petitioner testified that, for some time, she had been breaking up her day to avoid repetitive tasks but, on this date, she was working on a case where 14,055 grams of plant material were wrapped in layers of saran wrap, duct tape, and dryer sheets. The Petitioner testified that she cut the package open with a scalpel and X-acto knife, sampled it, and repackaged it. She testified that while repackaging the item, she experienced extreme pain in her right hand, wrist, fingers, arm, shoulder, neck and elbow.

A "Notice of Injury" form was eventually completed in which the Petitioner described an injury to her right hand which felt numb, cold, and tingly. She also reported that her right arm and right wrist area hurt the entire day and evening, and her right hand, right wrist, neck and right shoulder ached for several days. Timely notice of this injury is not disputed.

Following the July 3, 2001 injury, the Petitioner returned to Dr. Bednar at Loyola on August 14, 2001. Dr. Bednar noted that the Petitioner's symptoms were now more significant for numbness and tingling in the median nerve distribution. Dr. Bednar placed Petitioner on a 20 lbs. work restriction and discussed a future EMG test. Petitioner was also sent for biofeedback and occupational therapy which was performed at Rehabilitation Institute of Chicago. The Respondent accommodated the Petitioner's physical restrictions.

On November 13, 2001, Petitioner returned to Dr. Bednar, who noted no point tenderness, and that Petitioner could return to work without restrictions. However, Dr. Bednar also told Petitioner to change her tasks over the day and not be as repetitive. Dr. Bednar placed Petitioner at maximum medical improvement on this date.

The Petitioner then saw Dr. John Shea, a neurosurgeon at Loyola, from March to May of 2002. Dr. Shea noted right sided neck pain radiating to the right arm and hand and tingling into the right hand. Dr. Shea reviewed Petitioner's cervical MRI and did not see evidence of thoracic outlet syndrome. He allowed Petitioner to continue to work with the restrictions of Dr. Bednar.

On June 18, 2002, Dr. Bednar saw Petitioner again and his current diagnosis was pain of the neck and arms which are of undefined etiology. Dr. Bednar referred Petitioner to Dr. William Sullivan at Loyola in the physical medicine and rehabilitation department, to see if there was any further treatment available for Petitioner. Petitioner was allowed to return to work full duty without restriction on June 19, 2002. Dr. Bednar did note that the Petitioner's symptoms increased during the workday and aggravated her current condition, and that it was difficult to determine when she would reach maximum medical improvement.

On July 17, 2002, the Petitioner saw Dr. Sullivan who noted a diagnosis of chronic pain likely of myofascial origin in the shoulder and scapular regions. Dr. Sullivan showed Petitioner exercises, prescribed medications, and stated she was at maximum medical improvement. Dr. Sullivan recommended Petitioner take breaks throughout the workday.

Claim Number 04 WC 13736

The Petitioner testified that on November 25, 2003, she was injured for a fourth time. The Petitioner testified that over several days, she worked on a drug case that contained 57 small item baggies. The Petitioner testified that for each item, she was required to open the bag, weigh the specimen, mark it, write down the weight, complete preliminary testing on the color of the specimen using a dropper bottle, take another sample with the spatula, clean it off, mark the vial, add a solvent, use a pipette to decant the liquid into another vial, then crimp or screw the cap on a vial and mark it. The Petitioner testified that she needed to take frequent breaks and do her prescribed stretching throughout the project. She testified that she completed the case successfully, but experienced excruciating pain from holding the scalpels, pens, scissors, and other small and thin tools. She testified that the pain was tingling and radiated from her right thumb and wrist up to her elbow, right shoulder, and right neck. She reported the injury to her supervisor.

An "Employer's First Report of Injury" form was eventually completed and indicated a work accident of November 25, 2003 from repetitive motion while Petitioner was opening 57 bags of specimens for analysis. The report mentioned right shoulder and neck pain.

On February 6, 2004, the Petitioner sought treatment with Dr. Charles Carroll. Dr. Carroll noted a history of Petitioner's significant workload that involved multiple bags of data, wherein she developed pain in the shoulder, elbow, and hand. She complained of pain in the right neck, right chest, subclavicular region anterior shoulder, and along the course of the ulnar nerve. Dr. Carroll noted numbness and tingling in the right hand consistent with carpal tunnel syndrome. Dr. Carroll noted that there was evidence of right thoracic outlet syndrome and mild evidence of left thoracic outlet syndrome. Her neurological exam also showed evidence of ulnar neuritis and carpal tunnel syndrome. Dr. Carroll also noted possible shoulder instability. He recommended physical therapy and an MRI. He also allowed Petitioner to continue working but to not do heavy lifting and to vary her job tasks.

The Petitioner participated in physical therapy and occupational therapy at Northwestern Center for Orthopedics. She also underwent an MRI of the right shoulder on February 12, 2004 at High Tech Medical Park which was a normal study.

On February 23, 2004, Petitioner returned to Dr. Carroll who reviewed prior medical records and diagnostic studies. Dr. Carroll noted several positive physical and neurological examination findings and indicated that Petitioner had evidence of neuritis at the ulnar nerve and carpal tunnel region, even in the face of normal electrodiagnostic studies. She also had evidence of possible cervical radiculitis. Dr. Carroll recommended continued physical therapy, and an MRI of the cervical spine. He allowed Petitioner to continue working but instructed her to vary her job duties. Dr. Carroll considered Petitioner's present condition of ill-being to be aggravated by the work that she does.

Petitioner continued therapy, but with OccuSport physical therapy, throughout March and April 2004. On March 20, 2004, the Petitioner underwent a cervical MRI at High Tech Medical Park.

On May 5, 2004, Dr. Carroll noted a diagnosis of cervical spondylosis based on the March 20, 2004 MRI. Dr. Carroll recommended that Petitioner see Dr. Srdjan Mirkovic for the cervical condition and indicated that he has not yet determined that the cervical spine is the sole cause of her arm pain. Dr. Carroll noted that the Petitioner was not at maximum medical improvement but could continue working exercising care with highly repetitive activities.

Petitioner saw Dr. Mirkovic at Northwestern on June 16, 2004. Dr. Mirkovic noted complaints of neck and right arm pain radiating to the elbow and occasionally the hand with right shoulder pain. Dr. Mirkovic opined that the Petitioner's current symptoms were an aggravation of a pre-existing cervical spondylosis and he recommended a CT myelogram of the cervical spine.

The CT Myelogram was performed on August 2, 2004. Dr. Mirkovic reviewed the CT myelogram on August 17, 2004 and noted foraminal stenosis on the right at C4-5 greater than C5-6. Dr. Mirkovic noted that some of Petitioner's symptoms may be emanating from nerve root compression secondary to the foraminal stenosis. He discussed possible surgical options and recommended right C5 and C6 nerve root blocks.

On October 20, 2004, Dr. Jeff Katz performed the cervical epidural steroid injection to Petitioner's right C5-6. He noted that Petitioner's neck and shoulder felt 50 percent better after the injection. Her thumb pain was unchanged. She did not have any pain in the medial forearm, but also didn't have much pain in the forearm prior to the injection on this date. Dr. Katz noted that Petitioner could continue regular work duties but must wear an elbow pad for ulnar neuritis.

On November 9, 2004, Dr. Mirkovic noted Petitioner's benefit from cervical injection and recommended another injection. He diagnosed foraminal stenosis with radiculopathy.

Claim Number 06 WC 6834

The Petitioner testified that on November 3, 2005, she sustained a fifth injury. She testified that she had been working on a case that contained 51 items in paper bags. She had to perform the same series of steps on these items as with all the other cases, which resulted in severe pain in her right hand, right thumb, right wrist, right elbow, right shoulder, and neck. She told her supervisor on that date that she needed medical treatment. Timely notice of this injury is not disputed.

On February 17, 2006, the Petitioner returned to Dr. Carroll and complained of pain in the right elbow. Dr. Carroll diagnosed right lateral epicondylitis, cervical radiculitis, and sprains and strains of the right wrist and right hand. He ordered a new thumb Spica splint and allowed Petitioner to continue full duty work. Dr. Carroll considered the conditions work-related. Petitioner began physical therapy at OccuSport which she performed for six weeks.

The Petitioner returned to Dr. Carroll on April 14, 2006 and he noted Petitioner complained of chronic pain in the right elbow and some discomfort in the right lateral epicondyle. She also still had neck and right shoulder complaints. Dr. Carroll diagnosed triceps tendonitis and lateral epicondylitis.

Dr. Carroll referred Petitioner to Dr. Mirkovic and kept her at full duty. Petitioner continued physical therapy.

The Petitioner returned to Dr. Carroll on June 12, 2006 and he noted that her neurologic examination confirmed some epicondylitis and ulnar neuritis. Dr. Carroll recommended the Petitioner continue working, consider seeing a physiatrist, and follow up with a spine surgeon.

On August 1, 2006, Petitioner saw Dr. Mirkovic, who noted neck pain, right scapular and shoulder pain, and right arm ache. He prescribed an MRI of the cervical spine, and an EMG/NCV study of the upper extremity.

Petitioner underwent a cervical spine MRI on August 4, 2006 which showed multilevel degenerative changes. An EMG/NCV study performed on August 4, 2006 was reported to be an abnormal study indicative of chronic, mild, right C5-7 cervical polyradiculopathy without evidence of ongoing denervation. There was no electrodiagnostic evidence of a right medial mononeuropathy at the wrist or ulnar mononeuropathy.

Petitioner sought treatment with Dr. Brian Couri of the Chicago Institute of Neurosurgery and Neuroresearch on August 14, 2006. Dr. Couri's assessment included; 1) right-sided snapping scapula secondary to scapular stabilizing muscle weakness which is very prominent with significant scapular dysfunction; 2) right medial and lateral epicondylitis most likely due to overuse from the scapular dysfunction; 3) positive Hawkins' sign on the right side with right-sided impingement syndrome which is probably secondary to the scapular dysfunction with rotator cuff overuse and the weakness of the rotator cuff muscles; 4) bilateral neck pain over bilateral C2-3, C3-4, and C4-5 cervical zygapophyseal joints with left-sided osteoarthritis and right C1-2 zygapophyseal joint dysfunction, probably more secondary to the muscle imbalances but could very well be due to discomediated pain causing some pain in the cervical spine and leading to the capsular dysfunction; 5) Right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis which very well could be causing the patient to have the cervical spine pain and the shoulder pain leading to the scapular dysfunction which is the main cause of all of the rest of the patient's current symptoms; 6) Right-sided thoracic outlet syndrome, more prominent than that on the left side, which is more than likely functional in nature as opposed to any true impingement upon the thoracic outlet. It is probably more functional due to the scapular stabilizing weakness. Dr. Couri prescribed physical therapy and allowed Petitioner to continue full duty work.

Petitioner continued physical therapy at OccuSport and followed up with Dr. Couri. On October 9, 2006, Dr. Couri's assessment was a right C4-5 mild bulging disc with right mild-to-moderate foraminal stenosis; 2) right-sided functional thoracic outlet syndrome; 3) what appears to be a right very mild C5 radiculitis/radiculopathy; 4) right scapular dysfunction with shoulder impingement secondary to the C5 radiculopathy. Dr. Couri recommended a right C5 transforaminal epidural steroid injection, which was performed on October 31, 2006.

On November 7, 2006, the Petitioner was involved in an unrelated motor vehicle accident. The Petitioner testified that she was hit while making a U-turn and suffered *left* upper trapezius muscle pain and *left-sided* neck pain, neither of which exacerbated the right-sided neck pain she was experiencing from her work injury. The Petitioner testified that there was no injury to her right upper extremity in this automobile accident.

On November 13, 2006, Petitioner attended physical therapy with OccuSport and the therapist noted that Petitioner's recent motor vehicle accident affected the left upper trapezius and had no effect on the work-related right side. It was noted that the Petitioner reported an overall improvement in her right-sided symptoms since her epidural injection on October 31, 2006. On November 14, 2006 Dr. Couri noted that the motor vehicle accident caused left scapular/shoulder-area spasms and increased left sided neck pain, but that her right-sided neck pain did not become any worse. He allowed Petitioner to continue working full duty.

Dr. Couri performed additional injections to the right C2-3, C5-6, and C6-7 zygapophyseal joints on December 19, 2006. Petitioner continued therapy.

On February 2, 2007, Petitioner saw Dr. Couri again and he recommended that Petitioner continue full time work but to do one-third less cases, and to instead spend that time doing something like teaching which she had done in the past. Dr. Couri ordered another EMG/NCV test of the right arm and an elbow injection.

An MRI arthrogram of the Petitioner's right shoulder was performed on June 14, 2007 at Future Diagnostics Group and was reported to be unremarkable.

The Petitioner was then referred by Dr. Couri to Dr. Giridhar Burra at Hinsdale Orthopedic Associates on June 22, 2017. Dr. Burra noted several positive physical exam findings relative to the right shoulder. Dr. Burra reviewed diagnostics and made a diagnosis of biceps tendinitis and a possible superior labrum anterior and posterior lesion. Dr. Burra recommended a diagnostic right shoulder arthroscopy.

On July 16, 2007, Petitioner returned to Dr. Couri who agreed with Dr. Burra's plan of diagnostic right shoulder arthroscopy. Dr. Couri stated that "it appears all of her symptoms came about with chronic repetitive work and lifting of heavy objects, and I believe that her right shoulder is the main cause of her symptoms which has exacerbated the neck and now the elbow." Dr. Couri placed Petitioner on 10 lbs. lifting restrictions and no overhead work.

On August 1, 2007, Petitioner was involved in another unrelated motor vehicle accident. She was taken to Silver Cross Hospital and complained of a left upper arm abrasion, a right shoulder abrasion, and mid lower back pain. The Petitioner testified that she only experienced slight soreness on her left side as a result of this accident.

On September 21, 2007, Dr. Burra authored a letter indicating that Petitioner's right shoulder/bicep symptoms preceded the motor vehicle accident and that she never had relief of symptoms prior to the motor vehicle accident. Accordingly, Dr. Burra opined that her shoulder symptoms were primarily related to her work injury and did not believe that the motor vehicle accident caused the injury.

On June 4, 2008, the Petitioner underwent right shoulder surgery at Silver Cross Hospital with Dr. Burra. The post-operative diagnosis was a SLAP lesion, subacromial bursitis and mild impingement in the right shoulder. The procedure consisted of right shoulder arthroscopy, SLAP lesion repair and subacromial decompression. Following surgery, Petitioner continued following up with Dr. Burra and performing physical therapy.

On November 19, 2008, the Petitioner reported to Dr. Burra that her right shoulder was doing well with increasing motion. However, she had a complaint on this date of rather extreme exacerbation of left elbow epicondylitis. She was diagnosed with left lateral epicondylitis. Dr. Burra recommended therapy for both the right shoulder and left elbow, and to remain restricted at work.

On January 7, 2009, Dr. Burra noted that Petitioner had made great progress with the right shoulder and could discontinue therapy and progress to a home exercise program. Dr. Burra placed Petitioner on restrictions for the right shoulder of no lifting greater than 25 lbs. and recheck in 6 weeks. Relative to the left elbow, Petitioner still complained of left elbow pain, worse with any gripping or lifting. Dr. Burra recommended a cortisone injection and continuation of physical therapy. The injection was done on this date. Dr. Burra also placed restrictions of no gripping with the left arm.

On April 17, 2009, Dr. Burra noted that Petitioner was pretty much asymptomatic for the right shoulder. He placed Petitioner at maximum medical improvement for her right shoulder and allowed her to return to full duty without restriction. However, for her continued right elbow symptoms, Dr. Burra noted that Petitioner had previous complaints suggestive of ulnar neuritis. He also noted that people with shoulder surgeries are at a higher risk because of the significant amount of flexion with performance of the rehab and immobilization after shoulder surgery, and this would put this condition for an exacerbation. He diagnosed ulnar nerve neuropathy and recommended a night splint. For the left elbow, Dr. Burra performed another injection and discussed possible surgical intervention if not improved. She was returned back to work with restrictions of no gripping with the left hand.

On June 25, 2009, the Petitioner saw Dr. Burra and reported that she was symptomatic in regard to her right elbow, complaining of paresthesia to the right ulnar nerve distribution. She was also tender over the left lateral epicondyle in the left elbow. Dr. Burra stated that "her right shoulder pathology [was] related causally to her right elbow symptoms..." For the left elbow lateral epicondylitis, he stated it is not a traumatic condition but an overuse syndrome. Dr. Burra discussed surgical options and recommended an MRI of the left elbow. A left elbow MRI was performed on July 9, 2009 at Future Diagnostics Group.

Dr. Burra reviewed the MRI of the left elbow on July 29, 2009 and diagnosed left epicondylitis. However, Petitioner reported improvement in her symptoms, and wanted to defer any surgical intervention unless symptoms worsen. Dr. Burra allowed her to continue to work with limitations of no repetitive gripping in the left hand, and to follow-up as needed.

On August 1, 2009, the Petitioner returned to Dr. Mirkovic for neck and right shoulder pain, and he ordered an MRI of the cervical spine and an EMG/NCV of the right upper extremity.

The Petitioner returned to Dr. Burra on December 2, 2009 complaining of increased right shoulder pain that freezes, cracks and pops, as well as increased pain with overhead activities or reaching behind or across her body. Dr. Burra diagnosed right elbow lateral epicondylitis as well as cubital tunnel syndrome. He recommended a repeat MRI arthrogram, and also to return after the EMG was done relative to the right elbow.

The Petitioner returned to Dr. Burra on January 6, 2010. Despite a negative EMG, Dr. Burra felt that the Petitioner had left elbow cubital tunnel syndrome and recommended ulnar nerve transposition surgery. For the right elbow, he diagnosed lateral epicondylitis, and recommended conservative treatment. Relative to the right shoulder, the MRI arthrogram showed some post-

surgical changes, but Dr. Burra recommended trying to manage it conservatively. The Petitioner was kept on restrictions of no repetitive gripping and no lifting greater than 5 lbs.

On July 2, 2010, the Petitioner had another EMG with Dr. Wayne Kelly of Health Benefits Pain Management. The EMG was noted to be abnormal, and the impression was 1) a right-sided chronic underlying chronic C6-7 cervical radiculopathy with evidence of primarily chronic axonal involvement; 2) a superimposed right-sided mild chronic compression/entrapment ulnar neuropathy across the elbow (Cubital tunnel syndrome) with evidence of mild focal demyelination and mild chronic axonal involvement, likely indicative of a double crush injury; 3) a bilateral moderate chronic compression/entrapment median mono neuropathies at the wrist (carpal tunnel syndrome) with evidence of moderate focal demyelination of both sensory and motor nerves as well as chronic axonal involvement; 4) no electrophysiological evidence of an underlying sensory/motor polyneuropathy or right brachial plexopathy. Dr. Kelly recommended two C6-7 cervical injections, a right ulnar nerve steroid block along the ulnar nerve, and a right distal medial nerve steroid block at the carpal tunnel and use of cock-up wrist splints.

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The Petitioner testified that on August 2, 2010, she was injured for a sixth time when working on a case with several kilos of plant material wrapped in multiple layers of saran wrap. The Petitioner testified that she was using an X-acto knife to cut open the packages and enter the information into the computer. By the time she was done analyzing, sampling, and repackaging, her right and left hands, wrists, and thumbs were in significant pain.

The Petitioner reported the incident to her supervisor and an accident report was eventually completed. The Petitioner reported in the accident report that she was opening packaged kilos of cannabis. She had to cut open the package and remove the cannabis for weight and analysis. During these job duties, she felt pain in her right wrist, right elbow, left wrist, and bilateral hands. Timely notice of this injury is not disputed.

On August 16, 2010, the Petitioner returned to Dr. Burra, and she reported that her right shoulder pain was significantly resolved, and her left elbow pain was improved. She complained, however, that she was very limited and affected by her right elbow pain. She reported the recent work activity of opening multiple kilo packs which involved significant flexion/extension across her right elbow and had worsened her symptoms. Dr. Burra reviewed the EMG from July 2010. Dr. Burra indicated that Petitioner had a double crush condition. Dr. Burra recommended ulnar nerve transposition surgery.

Surgery was performed on September 28, 2010 to the right elbow. The pre-and-post operative diagnosis was ulnar nerve compression neuropathy of the right elbow. The procedure performed consisted of right-side ulnar nerve anterior transposition with a subcutaneous technique. Petitioner was placed on sedentary work/paperwork only duties.

Petitioner continued following-up with Dr. Couri in 2010 and did physical therapy for the post-operative right elbow.

On November 17, 2010, Dr. Burra recorded that Petitioner's numbness and tingling in her right 4th and 5th fingers was resolving post-surgery. Her left elbow was asymptomatic as of this date. Dr. Burra placed Petitioner on continued work restrictions.

On December 28, 2010, Dr. Burra noted that the Petitioner's right 4th and 5th finger symptoms had resolved. Her right elbow was doing much better. Noting that the Petitioner's right elbow, right shoulder, and left elbow symptoms were under control, Dr. Burra released her from his care. Dr. Bura indicated that the Petitioner was able to return to work relative to the right elbow, right shoulder and left elbow, but he noted that the Petitioner was still treating with Dr. Couri for carpal tunnel syndrome.

The Petitioner continued treatment with Dr. Couri in early 2011 for bilateral carpal tunnel syndrome. On January 10, 2011, she complained of bilateral hand symptoms which were improving. She still had a complaint of left elbow pain at this visit and she reported that her work aggravated both conditions. Dr. Couri kept Petitioner on work restrictions.

On March 25, 2011, Dr. Couri performed a left eblow lateral epicondyle injection, and instructed Petitioner to continue using a cock-up wrist splint. She was kept on work restrictions. On April 19, 2011, Dr. Couri recommended another cervical MRI, and kept Petitioner on work restrictions.

On May 23, 2011, Dr. Couri reviewed the April 26, 2011 MRI. Petitioner reported doing better with the left elbow pain since the injection. She was still having mild left lateral elbow pain and left sided neck pain. Dr. Couri recommended left C6 and C7 transforaminal epidural steroid injections and physical therapy, which Petitioner wanted to defer for the time being. She would instead try a home traction unit for one to two weeks first. She was kept on work restrictions. Dr. Couri performed an additional left elbow injection on August 2, 2011.

The Petitioner continued following up with Dr. Couri in 2012. By October 1, 2012, Dr. Couri noted that Petitioner had bilateral wrist pain and weakness. She reported numbness and tingling with fine motor activities, and also decreased grip. Dr. Couri's diagnoses was bilateral moderate carpal tunnel syndrome. He discussed bilateral percutaneous carpal tunnel release surgery in the future. She was kept on work restrictions.

On October 26, 2012, Petitioner underwent bilateral *percutaneous* carpal tunnel release surgeries with Dr. Couri.

She returned to Dr. Couri on December 6, 2012 who noted that the carpal tunnel releases had failed. He referred the Petitioner to Dr. John Fernandez at Midwest Orthopedics at Rush for another opinion.

The Petitioner saw Dr. Fernandez for the first time on January 9, 2013, and he diagnosed the Petitioner with bilateral carpal tunnel syndrome, bilateral thumb CMC joint osteoarthritis, and bilateral upper extremity pain. He recommended bilateral carpal tunnel release procedures.

On February 8, 2013, Petitioner underwent left wrist carpal tunnel release with Dr. John Fernandez. On February 25, 2013, Dr. Fernandez noted that Petitioner's paresthesias in the left hand had nearly completely resolved.

On April 12, 2013, Petitioner underwent right wrist carpal tunnel release surgery with Dr. Fernandez. Petitioner saw Dr. Fernandez on April 29, 2013, who noted improvement after right wrist surgery relative to numbness and tingling. Her main complaint on this day was pillar pain primarily worse on the right than left, worse with direct pressure of the palm and also worse with lifting activities. Dr. Fernandez noted that Petitioner could work with restrictions until June 1, 2013 at which time she would be at maximum medical improvement and able to return to full duty work.

The Petitioner testified that she lost one day of work for each carpal tunnel surgery and that the Respondent continued to accommodate her restrictions. She testified that she did less repetitive work and she participated in more teaching activities at work.

The Petitioner continued to work on restricted duty until May 31, 2013 when she voluntarily retired from her employment with the State of Illinois.

On May 27, 2015, the Petitioner returned to Dr. Fernandez with complaints of a bump/nodule on her left palm which was slightly tender to palpation and bothered her when performing gripping and working out activities. Relative to the right upper extremity, she complained of volar wrist pain. Her neurologic complaints from the median nerve distribution were completely resolved at this point. Dr. Fernandez performed a physical exam which noted a slight thickening of the surgical site along the left palm, and also a Dupuytren's nodule associated with the middle finger of the left palm. Relative to the right wrist, she had very minimal swelling along the volar aspect. She had full range of motion of the hand, wrist, and elbow. X-rays were performed which revealed ulnar positive variance by approximately 2mm. Dr. Fernandez' diagnoses were 1) left hand Dupuytren's disease, nodular phase; 2) bilateral upper extremity pain beginning while working as a chemist in 2012. Some medications were prescribed, and she was told to follow-up as needed.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

The Petitioner was examined at the request of her attorney by Dr. Samuel Chmell on October 15, 2015. Dr. Chmell's deposition testimony was admitted into the record as Petitioner's Exhibit 20. Dr. Chmell testified as to his understanding of the Petitioner's job duties and work history as well as her history of injuries and his examination findings. Dr. Chmell made the following seven diagnoses for the Petitioner: 1) bilateral carpal tunnel syndrome and multiple tendinitis, both wrists status post bilateral carpal tunnel releases times two; 2) right elbow cubital tunnel syndrome, status post ulnar nerve decompression and anterior transposition; 3) right shoulder SLAP lesion and impingement

syndrome, status post arthroscopy SLAP repair and subacromial decompression; 4) right shoulder snapping scapula syndrome; 5) bilateral elbow lateral and medial epicondylitis; 6) traumatic aggravation of degenerative disc disease in cervical spine with right upper extremity radiculopathy; and 7) right thoracic outlet syndrome.

Relative to causation, Dr. Chmell testified as to each of his seven diagnoses:

Relative to the bilateral carpal tunnel syndrome/multiple tendonitis hands and wrist, status post bilateral carpal tunnel release times two, Dr. Chmell testified that these conditions are causally related to Petitioner's work accidents of January 9, 1996, February 8, 2000, July 3, 2001, and August 2, 2010. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right cubital tunnel syndrome, status post ulnar nerve decompression and anterior decompression and interior transposition, Dr. Chmell testified that this condition was causally related to the July 3, 2001 and the August 2, 2010 work accidents. Dr. Chmell testified that all treatment for those conditions to date has been reasonable and necessary.

Relative to the diagnosis of right shoulder SLAP lesion and impingement syndrome status post arthroscopy, SLAP repair and subacromial decompression, Dr. Chmell testified that this condition was causally related to the work accident of November 25, 2003, which was aggravated on November 3, 2005. Dr. Chmell testified that this injury was a result of Petitioner's repetitive activities at work and that all treatment for those conditions to date has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right shoulder snapping scapular syndrome, Dr. Chmell testified that this condition is causally related to the November 25, 2003 work accident which was later aggravated during the November 3, 2005 work accident. Dr. Chmell testified that all treatment for this condition was reasonable, necessary, and causally related to the work accidents.

Relative to the diagnosis of bilateral elbow lateral and medial epicondylitis, Dr. Chmell testified that the right arm condition was causally related to the July 3, 2001 work accident and was further aggravated by the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell testified that the left elbow condition became involved after the August 2, 2010 work accident. Dr. Chmell opined that all treatment to date for these conditions has been reasonable, necessary, and related to the work accidents.

Relative to the diagnosis of cervical spinal traumatic aggravation of degenerative disc disease with right upper extremity radiculopathy, Dr. Chmell testified that this condition was causally related to the work accident of February 8, 2000, and further aggravated by the July 3, 2001, November 3, 2005, and August 2, 2010 work accidents. The condition was confirmed by positive EMG findings following the November 3, 2005 work accident. Dr. Chmell opined that all treatment to date for this condition has been reasonable and necessary and related to the work accidents.

Relative to the diagnosis of right thoracic outlet syndrome, Dr. Chmell testified that this condition was causally related to the February 8, 2000 work accident, which was later aggravated during the November 25, 2003 and November 3, 2005 work accidents. Dr. Chmell opined that all

treatment for this condition to date has been reasonable, necessary, and related to the work accidents.

Dr. Chmell reviewed several accident reports which were included in Petitioner's Deposition Exhibit #4 at the deposition and noted that Petitioner's job duties as described in the reports are consistent with the type of activity that could cause the conditions he diagnosed.

Dr. Chmell opined that as of the date he saw Petitioner on October 15, 2015, Petitioner was at maximum medical improvement. Dr. Chmell also opined that Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma. Finally, Dr. Chmell testified that Petitioner's work restrictions in this case have been related to her work injuries.

Dr. Chmell testified that he disagreed with Dr. Verma's conclusion that the Petitioner's work was not consistent with a mechanism to cause A-C joint arthrosis or biceps tendon superior labral tearing. Dr. Chmell opined that repetitive motion activities can affect the shoulder when the labrum is stressed and eventually shreds and tears. Dr. Chmell further disagreed with Dr. Verma's conclusion that Petitioner reached MMI on March 17, 2008. Dr. Chmell disagreed because he believed Petitioner's shoulder surgery on June 4, 2008 helped her condition.

At the request of the Respondent, the Petitioner was examined by Dr. Nikhil Verma on March 17, 2008 and April 17, 2017 and he performed a record review on January 10, 2018. Dr. Verma's April 4, 2018 deposition testimony was admitted into the record as Respondent's Exhibit 20.

With regard to his examination of the Petitioner on March 17, 2008, Dr. Verma testified that he examined the Petitioner and reviewed the Petitioner's medical records from 2002 through 2007. Dr. Verma testified that he didn't review a written description of the Petitioner's job duties in preparation for the exam but the Petitioner described to him that her work as a forensic scientist involved using her hands for fine work, including opening small packages and testing substances and powders. Dr. Verma's diagnosis was right upper extremity pain with possible cervical spondylosis and radiculopathy. Dr. Verma did not believe this to be causally related to her job duties, because he did not locate a diagnosis within the shoulder that would be responsible for her symptoms, which he viewed to be diffuse in nature and not explained by the Petitioner's AC joint, biceps, or SLAP problems. Dr. Verma further testified that a repetitive use type mechanism is not consistent with a SLAP pathology in an individual of the Petitioner's age group.

Dr. Verma stated that degenerative changes in the labrum are common for patients in Petitioner's age group, and that the only repetitive use mechanism that generates SLAP tears is throwing a baseball at 80-plus miles per hour, which is not an activity in which he believed Petitioner was participating. Dr. Verma stated that repetitive work would be similarly inconsistent with superior labral pathology. Dr. Verma did not believe that the Petitioner's clinical exam findings supported the diagnosis of superior labral pathology, given their diffuse nature involving multiple components of her upper extremity.

Dr. Verma opined that Petitioner did not require any additional medical treatment for her shoulder related to a work injury, did not require any work restrictions, and was at maximum medical improvement.

With regard to his examination of the Petitioner on March 17, 2017, Dr. Verma testified that he reviewed the Petitioner's medical records from Dr. Burra, pain management records, records from Hinsdale Orthopedics, and records from Dr. Chmell. Dr. Verma noted that Petitioner's bilateral shoulders were normal aside from healed incisions on the right side and he indicated that the Petitioner demonstrated full range of motion, normal cervical motion, normal neurovascular systems, and no provocative testing findings on either shoulder. Dr. Verma opined that the Petitioner's right shoulder was essentially normal both objectively and subjectively. She had undergone right shoulder SLAP repair, which Dr. Verma did not believe was causally related to the work activities. Dr. Verma also opined that Petitioner was at maximum medical improvement for the shoulders, that no additional treatment was needed, and that she did not require any work restrictions relative to the shoulders.

With regard to his review of additional medical records of the Petitioner's treatment from 1996 through 2010, Dr. Verma testified that he also reviewed a job description in conjunction with authoring this report. Following his review of the updated records, Dr. Verma diagnosed the Petitioner with chronic upper extremity pain with possible fibromyalgia-type symptoms. Dr. Verma again stated that he did not believe Petitioner's condition to be causally related to her job duties.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

After reviewing all testimony and evidence, the Arbitrator hereby finds that the Petitioner did sustain accidents that arose out of and in the course of her employment by the Respondent on January 9, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010. The accidents are supported by the Petitioner's testimony and corroborated by the accident reports and the treating medical records.

The respondent did not call any witnesses to dispute the Petitioner's version of her job duties or how the accidents occurred.

With regard to the issue of Notice, the Arbitrator notes that the Respondent only disputed the issue of timely notice with regard to the initial injury of January 9, 1996 (Claim Number 04 WC 13698). Based upon the Petitioner's unrebutted testimony, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Several of Petitioner's treating physicians provided opinions as to causation in this case over the years.

On March 27, 1996, while referring to Petitioner's soft tissue/tendons in the right forearm, Dr. Brannegan noted that "it sounds as if [Petitioner's] work demands a fair amount of repetitive fine hand movement, and this probably aggravates this problem."

Dr. Bayliss indicated in February and March of 2000 that Petitioner's symptoms are related to the ergonomics of her workstation and recommended altering the workstation.

Kurt James Keppner, D.C. noted on April 28, 2000 that Petitioner's condition has deteriorated over the last four months caused by her overuse at an ergonomically unsound workstation that places undue stress and strain on her neck and upper back.

On May 30, 2002, Dr. Shea at Loyola noted that "working aggravates all of her symptoms" while discussing Petitioner's neck, right arm, right thumb and grip strength.

On June 18, 2002, Dr. Bednar noted "I believe the work that she does aggravates her current condition." He also ordered her workstation be modified.

On February 6, 2004, Dr. Charles Carroll at Northwestern noted "[Petitioner] has an ongoing problem which has been further aggravated by her more recent work stress" while discussing a possible diagnosis of neuritis of the upper extremity. On February 26, 2004, Dr. Carroll stated, "I have considered her present condition of ill-being to be aggravated by the work that she discussed in previous correspondence."

Dr. Burra at Hinsdale Orthopedics stated on August 16, 2001 that "while the shoulder per se does not cause her ulnar nerve symptoms at the elbow... I have seen incidence or worsening of cubital tunnel syndrome following shoulder surgery because of the degree and duration of flexion that is required across the elbow both in the immediate postoperative period while she is in the sling as well as during the course of rehabilitative exercise and physical therapy following shoulder surgery, and I have seen this in my practice where there is an aggravation of this. As such, there is some relationship between her shoulder surgery and her elbow symptoms."

Dr. Burra also opined as to causation for the right shoulder SLAP lesion and biceps tendinitis in his September 21, 2007 correspondence. In this note, Dr. Burra opined that there is a clear-cut causal relationship of the work injury of November 3, 2005 to the right shoulder condition. He ruled out the auto accident as a cause of her condition.

Dr. Samuel Chmell, who examined the Petitioner at her attorney's request, testified that the sum of all the Petitioner's job duties involved repetitive stressful and difficult movements of Petitioner's upper extremities, right greater than left. He testified that the Petitioner did these tasks for 32 years, which was significant because her job duties subjected her upper extremities to repetitive motion activities, which is akin to overuse activities. Dr. Chmell testified that the Petitioner's job duties are consistent with the type of activity that could cause the conditions diagnosed in this case.

Dr. Chmell found seven diagnoses, which he opined were causally related to one or more of the work accidents in this case. Dr. Chmell noted that the Petitioner did not have any problems with her neck or upper extremities prior to working as a forensic chemist for the Respondent. Dr. Chmell

opined that the following seven diagnosed conditions were causally related to the Petitioner's work accidents:

1) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Nikhil Verma, the Respondent's examining physician, opined that Petitioner's diagnosis was chronic upper extremity pain with possible fibromyalgia-type symptoms. He did not feel that these conditions were causally related to her job duties. Dr. Verma only evaluated Petitioner relative to her bilateral shoulders and he did not evaluate her for any other body parts or conditions.

After reviewing all of the medical records, testimony and evidence, the Arbitrator finds the causation opinions of Petitioner's treating doctors to be consistent with the evidence and persuasive. The opinions and testimony of Dr. Samuel Chmell are credible and well-founded. Dr. Chmell's opinions correlate with those of Petitioner's treating doctors. Dr. Chmell also understood Petitioner's job duties consistent with Petitioner's testimony. While the Arbitrator notes the findings and opinions of Dr. Verma, the Arbitrator finds the causation opinions of the Petitioner's treating physicians, including Drs. Brannnegan, Carroll, Bayliss, Keppner, Shea, and Bednar to be persuasive. The Arbitrator also finds the opinions of Dr. Sam Chmell to be sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's work injuries on January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

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:

At trial, Petitioner submitted evidence of unpaid medical bills totaling $58,148.92, as summarized in Petitioner's Exhibit 31. Dr. Chmell testified that all medical treatment rendered to the Petitioner for her diagnosed conditions was reasonable, necessary, and causally related to the work accidents in this case. The Arbitrator hereby adopts the opinions of Dr. Chmell, which are sufficiently credible and persuasive so as to satisfy the Petitioner's burden of proof and finds that the unpaid medical bills totaling $58,148.92 set forth in Petitioner's Exhibit 31 are reasonable, necessary, and causally related to the work accidents of January 1, 1996, February 8, 2000, July 3, 2001, November 25, 2003, November 3, 2005, and August 2, 2010.

Additionally, the Petitioner submitted evidence of out-of-pocket travel/mileage costs as summarized in Petitioner's Exhibit 31. Section 8(a) of the Act states that the employer shall pay for treatment, vocational rehabilitation, and all services reasonably required to cure or relieve the effects

of the accidental injury. 820 ILCS 305(8)(a). Travel expenses are awarded in cases where it was reasonably necessary for the petitioner to travel in order to receive medical treatment. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). Here, the Petitioner's travel for treatment from 1996 through 2012 was for physical therapy, doctor's appointments, and testing, which all constitute reasonable travel expenses under the law. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate.

The Petitioner's mileage for travel to and from medical appointments as submitted in Petitioner's Exhibit 31 totals 17,629 miles. Applying the appropriate "IRS medical" rate applicable at the time of the travel, results in the total amount of $2,841.00 due. Accordingly, the Petitioner is entitled to mileage reimbursement at the "IRS medical" rate in the amount of $2,841.00.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she underwent surgery to her right shoulder on June 4, 2008 and that she was off work as a result of that surgery through July 29, 2008, a period of 8 weeks. The Petitioner testified that she underwent surgery to her right elbow on September 28, 2010 and that she was off work as a result of that surgery through October 2, 2010, a period of 5/7 weeks. The Petitioner underwent surgery to her left and right hands on February 8, 2013 and April 12, 2013, respectively, and that she was off work for one day after each of those surgeries, a period of 2/7 weeks. Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits for the periods of June 4, 2008 through July 29, 2008, a period of 8 weeks, September 28, 2010 through October 2, 2010, a period of 5/7 weeks, February 8, 2013, a period of 1/7 weeks, and April 12, 2013, a period of 1/7 weeks.

While the Petitioner claimed to be entitled to Temporary Partial Disability benefits for the hours of work that she missed obtaining treatment and therapy, the Arbitrator finds that the Petitioner failed to provide sufficient specific evidence of the actual periods of disability to allow the calculation of the exact amount of Temporary Partial Disability benefits that may be due, if any. The Arbitrator finds, therefore, that the Petitioner failed to meet its burden of proof with regard to what Temporary Partial Disability benefits, if any, are due. Accordingly, no Temporary Partial Disability benefits are awarded herein.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that Dr. Fernandez, the last physician who treated the Petitioner, noted that the Petitioner would be at maximum medical improvement by June 1, 2013 at which time she would be able to return to full duty work.

The Petitioner testified that she retired from her employment with the Illinois State Police Crime Laboratory on May 31, 2013. She testified that currently, she continues to have symptoms and physical limitations as a result of her work injuries. She testified that she has difficulty with opening or closing jars, peeling vegetables or fruit for cooking, getting dishes out of the oven or placing them into

the oven. The Petitioner testified that struggles with threading a needle, sewing, or completing any other fine motor activities, and can only wear very light jewelry around her neck and only for short periods of time until the pressure on her neck causes her arm to go numb. She testified that she can only wear a strapless bra because of the pressure the straps place on her shoulders. She testified that she cannot wear a watch or any bracelets because the pressure on her right wrist will cause her right hand to go numb. The Petitioner testified that she has difficulty using a hairdryer and reaching over her head to dry her hair and difficulty buttoning or zipping clothing that has a back closure. She testified that she limits the amount of time she spends cooking and preparing food. She testified that activity causes her symptoms to increase, and that she treats her symptoms with ice and relaxation, and that she stretches her neck, right shoulder and lower body every day.

Dr. Chmell, who examined the Petitioner at the request of her attorney on October 15, 2015, found seven diagnoses, which he opined were causally related to one or more of the Petitioner's work accidents:

2) Bilateral carpal tunnel syndrome and multiple tendinitis, for which the Petitioner underwent two surgeries;
2) Right cubital tunnel syndrome, for which the Petitioner underwent surgery;
3) Right shoulder SLAP lesion and impingement syndrome for which the Petitioner underwent arthroscopy;
4) Right shoulder snapping scapular syndrome ;
5) Right elbow lateral and medial epicondylitis;
6) Aggravation of degenerative cervical disc disease with right upper extremity radiculopathy;
7) Right thoracic outlet syndrome.

Dr. Chmell opined that the Petitioner was at maximum medical improvement. Dr. Chmell also opined that the Petitioner has permanent disability and impairment involving her cervical spine and her upper extremities. Dr. Chmell testified that these impairments are related to a cumulative process of 32 years of repetitive motion trauma.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a cumulative result of the Petitioner's six work injuries the Petitioner sustained permanent partial disability to her whole person to the extent of 27% thereof.

In Support of the Arbitrator's Decision relating to (N.), Is Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent claimed a credit under Section 8(j) of $17,894.58 (04WC13699); $3,955.04 (04WC13736); $33,044.57 (06WC6834). Respondent entered exhibits #13, 14, and 15 in support of their alleged 8(j) credit. Petitioner disputed the Respondent's entitlement to an 8(j) credit at the time of arbitration.

However, after the hearing on June 4, 2019, the parties entered into a stipulation on June 5, 2019 wherein they agreed that "the payments made by the Respondent referred to and contained in Respondent's exhibits 13, 14, and 15 were made by the workers' compensation claims department who administers, pays, and adjusts workers' compensation claims for the State of Illinois. The State

of Illinois is a self-insured employer under the Illinois Workers' Compensation Act. They are not payments made by a group insurance carrier."

The Arbitrator finds that the Respondent is entitled to credit for all of the 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC028348
Case Name	MCGLOWN, LAWANDA v. AGENCY FOR COMMUNITY TRANSIT
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0211
Number of Pages of Decision	5
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Michael Keefe

DATE FILED: 4/21/2021

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

LAWANDA MCGLOWN,

Petitioner,

vs. Nos. 17 WC 028348

AGENCY FOR COMMUNITY TRANSIT,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §8(a) and §19(h)

This matter comes before the Commission on Petitioner's §8(a) and §19(h) Petition filed on February 13, 2020 seeking additional medical benefits and an increase in permanent disability under §19(h). On December 17, 2018, in his nature and extent decision, the Arbitrator awarded Petitioner permanent partial disability of 5% loss of use of the person as a whole for her low back and neck injuries suffered when the bus she was driving was rear-ended by another vehicle.

A hearing was held before Commissioner Parker on February 23, 2021, and a record was taken. Petitioner seeks medical benefits for post-arbitration treatment under §8(a) and prospective medical care. She no longer argues that her disability has increased.

FINDINGS OF FACT

Petitioner sustained compensable injuries on August 5, 2017, when the bus she was driving was rear-ended by a third party. Prior to arbitration, the parties stipulated that the sole issue before the Arbitrator was the nature and extent of Petitioner's permanent disability.

On September 28, 2017, Dr. Matthew Gornet evaluated Petitioner. He had performed fusion surgery at L5-S1 for Petitioner in May 2010. Petitioner provided a consistent history of her August 2017 accident and complained of low back, buttocks and hip pain but denied having any significant leg pain. Dr. Gornet noted that an MRI performed that day revealed a "subtle suggestion" of an annular tear at L4-5. He diagnosed Petitioner with discogenic low back pain and prescribed medication and continued chiropractic care.

On December 18, 2017, Dr. Gornet re-examined Petitioner and diagnosed a possible L4-5 disc injury, as well as an aggravation of her pre-existing facet arthropathy. A CT-scan performed that day revealed facet changes at L4-5, and Dr. Gornet referred Petitioner to Dr. Helen Blake for pain management.

Dr. Blake performed a median nerve branch block at L4-5 on January 30, 2018 and a radiofrequency ablation at that level on February 13, 2018. Petitioner reported to Dr. Gornet on March 8, 2018 that these procedures had eased her complaints, but Dr. Gornet warned Petitioner that any improvement was likely temporary and could diminish in six to 12 months.

Dr. Benjamin Crane, an orthopedic surgeon, performed a Section 12 exam at Respondent's request on April 5, 2018. He reviewed Petitioner's medical records and diagnostic studies and diagnosed Petitioner with low back pain that was causally related to her work accident. He found her at MMI and opined that she could return to work full duty. Dr. Crane retained these opinions after reviewing video of the accident.

On May 7, 2018, Dr. Gornet saw Petitioner for the last time prior to arbitration. In his office notes, he confirmed his opinions that Petitioner suffered from discogenic or structural back pain that was directly related to her August 2017 motor vehicle accident. Dr. Gornet reiterated his concern that benefits from Dr. Blake's pain management procedures would diminish over time. He found Petitioner at MMI and allowed her to return to work full duty but warned that she might need additional treatment, including radiofrequency ablations, in the future.

Petitioner testified at arbitration to occasional low back pain that was activity related, provoked by bending and turning. She took over-the-counter pain medication a few times a week. The Arbitrator in his December 17, 2018 nature and extent decision found Petitioner had suffered permanent partial disability to the extent of 5% loss of use of the person as a whole. Neither party sought review of the Arbitrator's decision.

Dr. Gornet testified on March 21, 2019 in a deposition taken in conjunction with Petitioner's third-party civil action against the driver who had caused her work accident. Dr. Gornet testified that the last time he saw the Petitioner before the August 5, 2017 accident was on February 2, 2012. He Further testified that the August 5, 2017 accident caused a disc injury at L4-5 and aggravation of pre- existing asymptomatic arthropathy and stated that the medial branch blocks and facet rhizotomies performed by Dr. Blake merely stun or kill a part of the nerve. The nerve will grow back within six to 12 months, and the pain will most likely return, so that these treatments may need to be repeated. He further testified that if Petitioner's disc continued to deteriorate, a fusion or disc replacement procedure may become necessary.

Petitioner returned to see Dr. Gornet on October 10, 2020 because of low back pain. His office note reflects the following:

> We have talked about potential other treatment with RFAs, etc. These tend to wear off and if she needs to, we will repeat these. I have asked her to contact me. I will follow-up with

her as needed. She understands my door is open, but I do believe she will require further treatment in the future if she continues to be symptomatic.

While acknowledging that Petitioner may require further treatment in the future, Dr. Gornet made no specific recommendations for prospective treatment at the time of Petitioner's October 10, 2020 appointment. This was Petitioner's only visit to Dr. Gornet or any other provider seeking treatment for her low back pain between the filing of the Arbitrator's Decision on December 17, 2018 and the review hearing on February 23, 2021.

Dr. Russell Cantrell performed a §12 exam at Respondent's request on October 20, 2020. His diagnosis was facet degenerative changes that were temporarily aggravated as a result of the work accident. He found that the aggravations had resolved at the time of his exam and recommended no further treatment.

Petitioner testified at the review hearing that she continues to experience occasional low back pain, depending on her activity and takes over-the-counter pain medications, as needed. She denied suffering any back injuries since her work accident.

CONCLUSIONS OF LAW

Section 8(a)

Pursuant to §8(a) of the Act, Petitioner is entitled to any and all necessary care to cure or relieve the effects of her work-related injuries. 820 ILCS 305/8(a). Upon establishment of a causal nexus between the injury and Petitioner's current condition of ill-being, Respondent is liable for all medical care reasonably required in order to diagnose, relieve, or cure the effects of her work injuries. *Plantation Mfg. Co. v. Industrial Comm'n,* 294 Ill. App. 3d 705, 709 (2d Dist. 1997). An employer's liability for medical services under §8(a) of the Act is continuous so long as it as the services are required to relieve the injured employee from the effects of the injury. *Efengee Elec. Supply Co. v. Industrial Comm'n,* 36 Ill. 2d 450, 453 (1967).

Petitioner contends that her ongoing complaints of pain are related to her August 5, 2017 work accident. She seeks payment of the cost of her October 10, 2020 office visit to Dr. Gornet and prospective medical care. Respondent argues that Petitioner's current complaints are not related to her August 5, 2017 accident but to her prior fusion at L5-S1 or to progressive age-related degeneration. The Commission finds that Petitioner's current low back complaints are related to the August 5, 2017 accident. Her complaints have been consistent since the time of that accident. Dr. Gornet has continued to manage her treatment and has related her symptoms to her work injuries, damage to the disc at L4-5 and aggravation of her pre-existing facet arthropathy. Based upon a review of the entire record, the Commission finds that Petitioner continues to suffer from the ill effects of her work injury and that her visit to Dr. Gornet post-arbitration was causally related to that work injury. The Commission therefore grants Petitioner's §8(a) petition with regard to her October 10, 2020 visit with Dr. Gornet and awards Petitioner the fee schedule amount of the charge for that visit, pursuant to §8(a) and §8.2 of the Act. The Commission finds that while Dr. Gornet mentioned Petitioner may need further treatment in the future, he did not prescribe or

recommend any further treatment at the October 10, 2020 appointment, so no prospective medical care is awarded at this time.

Section 19(h)

Petitioner no longer argues that her condition merits a reconsideration of the permanency awarded by the Arbitrator. Therefore, the Commission denies the §19(h) portion of Petitioner's petition for review.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §8(a) Petition for additional medical benefits, as documented in Petitioner's Exhibit 3 (consisting only of Dr. Gornet's charge for Petitioner's October 10, 2020 office visit), is granted, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's §19(h) Petition for increased permanency is denied.

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 $700.00. 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: **4/21/2021**

r-2/23/21
mp/dak
68

/s/ *Marc Parker*

/s/ *Barbara N. Flores*

/s/ *Christopher Harris*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC038045
Case Name	HENDERSON, JEFFERY MICHAEL v. SAFEWAY SCAFFOLDING/
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0212
Number of Pages of Decision	20
Decision Issued By	Barbara N. Flores, Commissioner

Petitioner Attorney	Edward Unsell
Respondent Attorney	Toney Tomaso

DATE FILED: 4/29/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffery Michael Henderson,

Petitioner,

vs. NO: 18 WC 38045

Safeway Scaffolding/Safeway Services LLC,

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 average weekly wage, temporary total disability benefits, maintenance and vocational rehabilitation, prospective medical care, penalties and fees, and Petitioner's request for a special finding, 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 Comm'n*, 78 Ill. 2d 327 (1980).

The Commission elaborates on the Decision of the Arbitrator with respect to the issues of temporary total disability benefits, maintenance and vocational rehabilitation, and Petitioner's request for a special finding.

I. Temporary Total Disability (TTD) and Maintenance/Vocational Rehabilitation

The Arbitrator concluded that Petitioner was entitled to temporary total disability (TTD) benefits for the period from November 14, 2018 through July 8, 2019. The Arbitrator also concluded that Petitioner was not entitled to maintenance benefits.

The Arbitrator found that when Respondent offered light duty work to Petitioner in June 2019, it would have been too burdensome for Petitioner to travel from his home to the work site due to the flood conditions near Petitioner's home at that time. However, the Arbitrator reasoned that once the ferry resumed service on July 9, 2019, Petitioner's surmise that the position was a "sham job" based on his "situational experience" was not a basis for a refusal to return to work. The Arbitrator also noted that Respondent's safety manager, Pamela Brangenberg, credibly testified that the light duty work planned for Petitioner was a *bona fide* job. The Arbitrator further observed that Petitioner testified that he decided to seek other work as early as March 2019 and applied for a job on June 3, 2019, which raised questions regarding Petitioner's credibility on this issue.

The Illinois Appellate Court has upheld Commission decisions to deny TTD benefits despite the need for continued treatment where the employee voluntarily ceased working despite the availability of a position within the employee's medical restrictions. For example, in *Presson v. Industrial Comm'n*, 200 Ill. App. 3d 876, 880-81 (1990), the court upheld the Commission's finding that the period of TTD ended when the claimant was offered a light-duty job within her restrictions, but she refused to even attempt to do the job. Similarly, in *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886-88 (1990), where three doctors cleared the claimant to return to light-duty work and the employer provided a job within the restrictions, the court upheld the Commission's denial of TTD benefits following the claimant's refusal to work the light-duty position, noting that there was no medical testimony corroborating the claimant's testimony that she could not work at the light-duty position. In this case, there was evidence that Petitioner might not be able to return to full-duty work as an insulator as of March 2019, when he began to consider retraining, but no evidence that Petitioner could not return to light-duty work. To the contrary, Petitioner was released to work with restrictions as of May 17, 2019 and, as the Arbitrator noted, Petitioner sought work with other employers within his restrictions beginning in June 2019.

Petitioner objects to the Arbitrator's conclusions based on his treating physician, Dr. James Coyle, having issued a work note providing for intermittent sitting and standing on a 30-minute interval. However, the record establishes that Dr. Coyle added the sitting restriction based on Petitioner's complaint on July 2, 2019, after Respondent offered Petitioner light duty work. Respondent's Section 12 examiner, Dr. Andrew Wayne, noted that Petitioner was not subject to a sitting restriction as of May 17, 2019 and opined that Petitioner did not require any sitting restrictions at that time. Dr. Wayne also opined that there is no clinical, diagnostic study, or physiologic reason why Petitioner could not tolerate driving his vehicle either to work or medical appointments between the middle of May 2019 through the current date.

Petitioner asserts that there was never a confirmation of a job or concrete job offer within Petitioner's restrictions, which is contradicted by Respondent's Exhibit 5, a June 6, 2019 email Respondent sent to Petitioner, requesting that Petitioner return to work on June 10 after returning to a training facility. Petitioner also asserts that the offer represented a "gotcha" moment perpetrated by Respondent's counsel, though there is no evidence to support the proposition. Petitioner further points to the fact that Ms. Brangenberg did not return the telephone call he placed in July 2019 to accept the light duty job and states that there was never any explanation as to why she did not return the call. Ms. Brangenberg's testimony establishes that this type of

contact from an employee was atypical, reported it to Respondent's counsel and left the matter with him, understanding that Petitioner's return to work was matter of dispute. Respondent's Exhibit 6, a July 10, 2019 email from Respondent's counsel to Petitioner's counsel, confirms that the issue of Petitioner's request for a new work restriction (*i.e.*, sitting/standing), his return to work a month after Respondent's offer, and Petitioner's request for vocational rehabilitation were all in dispute.

The Arbitrator correctly concluded that Petitioner's varying accounts of why he did not accept Respondent's offer of light-duty work raises questions regarding his credibility on whether Respondent's job offer was concrete or a "sham" as he suggests. Petitioner relies on the widely known flood near his home as the basis on which the Commission should determine that Respondent's job offer was a sham, but this is only one of multiple reasons Petitioner has offered for refusing the job offer. Petitioner asserts that the job offer was a sham not only because he could not get there due to the flood, but also because of his personal understanding of the purported light duty work, and because his subjective symptoms – which were not restricted at the time – would have prevented him from performing the work that he says could not have existed in the first place. Other than a one-month travel limitation due to a flood, the record does not support Petitioner's contentions that Respondent did not, in fact, have light duty work available within his restrictions in June or thereafter.

Simultaneously, Petitioner asks that his search for other employment months before Respondent made its job offer be ignored as a red herring. The record in this case establishes that Petitioner considered retraining as early as May 2019, applied for other work in June 2019, and asserted that Respondent's job offer was a sham based on "situational experience" that was not explained adequately by Petitioner's testimony, the testimony of Petitioner's witnesses, or the cross-examination of Respondent's witnesses. Given this record, the Commission concludes that Petitioner never intended to return to work for Respondent and his telephone call after the flood receded was an act entirely inconsistent with Petitioner's own testimony that the job offered was, in his "situational experience," a sham.

For all of the aforementioned reasons, the Commission affirms and adopts the Arbitrator's award of TTD benefits. The Commission further determines as a clerical matter that the period from November 14, 2018 through July 8, 2019 constitutes 33 and 6/7ths weeks, rather than the 34 weeks calculated in the Decision of the Arbitrator.

The Arbitrator relied upon the same reasoning to deny Petitioner's claim for maintenance benefits. Rehabilitation is neither mandatory for the employer nor appropriate if an injured employee does not intend, although capable, to return to work. *Euclid Beverage v. Illinois Workers' Compensation Comm'n*, 2019 IL App (2d) 180090WC, ¶ 31 (citing *Schoon v. Industrial Comm'n*, 259 Ill. App. 3d 587, 594 (1994)). In this case, in light of the totality of the record, the Commission finds that Petitioner refused Respondent's offer of light-duty work. Petitioner consulted with a vocational counselor in July 2019, but the counselor's reports were ruled inadmissible as hearsay because Mr. Dolan did not testify at the hearing. Petitioner submitted only three job applications as evidence of his job search from June 3, 2019 through January 3, 2020. Given this record, the Commission affirms and adopts the Decision of the Arbitrator denying maintenance benefits and vocational rehabilitation.

II. Special Finding

Petitioner also requests a special finding answering the following question: "Can a designated corporate representative, who has been present through the majority of Petitioner's case in chief, be called as an adverse witness in Petitioner's case?" The Commission notes that Petitioner did not preserve the issue whether the Arbitrator's ruling was in error in either his petition for review or statement of exceptions. With respect to the particular facts of this case, the Commission notes no prejudice resulted from the Arbitrator's ruling on the mode and order of interrogating Ms. Brangenberg whom Petitioner subjected to cross-examination. In essence, Petitioner requests an advisory opinion from the Commission, which it declines to provide.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's average weekly wage was $1,799.51.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,199.67 per week for the period November 14, 2018 through July 8, 2019, for a period of 33 and 6/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury, including $26,771.40 for temporary total disability benefits already paid and $17,147.55 in other benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary outstanding medical bills, pursuant to the fee schedule and §§8(a) and 8.2 of the Act, for the services provided to Petitioner from October 26, 2018 through October 14, 2019, as identified in Petitioner's Exhibit 7, excluding the bill for vocational services. Respondent shall receive 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 Petitioner is receiving this credit, as provided by §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical care is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for maintenance benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for vocational rehabilitation services is denied.

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

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 Decision of the Arbitrator filed on April 16, 2020 is hereby affirmed and adopted as modified herein.

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

Bond for the removal of this cause to the Circuit Court 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: **4/29/2021**
o: 3/4/21
BNF/kcb
045

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Deborah L. Simpson*
Deborah L. Simpson

Dissent in Part

I agree with the majority's special finding in this case, but I respectfully dissent from the majority decision, and would reverse the decision of the Arbitrator. The Arbitrator concluded that Petitioner refused to return to a light duty position affecting Petitioner's claim for temporary total disability (TTD) benefits. The Arbitrator also concluded that Petitioner, after undergoing a two-level lumbar fusion with hardware placement, was able to return to work as an insulator performing heavy duty work, regularly building and tearing down scaffolding. In my view, the evidence supports different conclusions.

The Arbitrator and the majority recognize that Respondent's expectation that Petitioner return to work light duty on June 10, 2019, in the middle of a historic flood, and terminating his TTD benefits as of that date was unreasonable. They have extended Petitioner's TTD benefits from June 9, 2019 through July 8, 2019 when the flood waters receded. I agree with that conclusion, but do not agree that Petitioner refused to return to a light duty job thereafter.

While it is true Petitioner testified that he believed the job was a "sham" and that he was looking for other work in March and April of 2019, it is undisputed that when flood waters began

receding in early July of 2019 he made multiple phone calls to Respondent's safety supervisor, Ms. Brangenberg, about returning to light duty work. Ms. Brangenberg admitted to receiving Petitioner's messages about returning to work as the flood waters were receding. She further admitted that she informed Respondent's counsel of Petitioner's calls and that he instructed her not to return those calls. The majority's acceptance of Respondent's position that contact between Ms. Brangenberg and the Petitioner while matters were in dispute is "atypical" ignores the fact that it was Respondent's counsel who instructed Petitioner's counsel to instruct Petitioner to contact Ms. Brangenberg to obtain details about the light duty job.

It is clear from the record that the Respondent believed it was justified in terminating benefits because Petitioner was unable to start the light duty position on June 10, 2019. The record, in my opinion, also reveals that the Respondent did not return Petitioner's calls in early July because it did not want to bring Petitioner back to a light duty position. I note that when Respondent's Section 12 physiatrist opined months later that Petitioner could return to full unrestricted duty, Respondent's counsel sent another email again instructing the Petitioner to contact Ms. Brangenberg directly about return to work details. Respondent's argument that Ms. Brangenberg returning Petitioner's calls in early July would have been "atypical" rings quite hollow. Even if the contact from Petitioner to Ms. Brangenberg was "atypical" prompting her referral of it back to Respondent's counsel, it was Respondent's counsel who instructed Petitioner's counsel to have his client contact Ms. Brangenberg directly on multiple occasions. Given Ms. Brangenberg's failure to respond to Petitioner's inquiries in her capacity as safety manager after the flood had receded, I would extend Petitioner's TTD benefits through October 14, 2019, the day Dr. Coyle released Petitioner from care with a 30 lb. lifting restriction among others.

Finally, in my view, Petitioner's belief that the light duty position was a "sham" simply is not relevant nor is his decision to begin looking for other positions in March and April of 2019. This claimant underwent a two-level fusion. Petitioner's search for other positions strikes me as a person planning for the future. The arbitrator and majority conclude that he never intended to return to work because of his belief that the job was a "sham," addressing Petitioner's credibility. Had Ms. Brangenberg returned Petitioner's calls there would be no need for such an analysis or conclusion.

In addition, the Arbitrator found that Respondent's Section 12 examiner, Physiatrist Wayne, was more persuasive that orthopaedic surgeon, Dr. Coyle. The arbitrator concluded that Petitioner could return to work without restrictions to the "heavy" job as an insulator building and tearing down scaffolding regularly. The majority affirms and adopts that conclusion. I disagree and would find surgeon Coyle's opinion that Petitioner has, a 30 lb. lifting restriction among others, more persuasive.

Shortly after his injury, the employer referred Petitioner to Dr. Dirkers. Because of the severity of Petitioner's condition, he referred Petitioner to Dr. Coyle. When Dr. Coyle believed a fusion surgery was warranted, Respondent requested that he see orthopaedic surgeon, Dr. Bernardi, for a second opinion. Surgeon Bernardi agreed that surgery was appropriate. On February 11, 2019, Dr. Coyle performed a two-level fusion of Petitioner's lumbar spine inserting hardware.

Following surgery, Petitioner stopped narcotic pain medicine within two weeks, was walking a mile or two within four weeks, and was eventually walking seven miles a day in May of 2019. Formal therapy was not required because of Petitioner's own efforts to improve his condition. On October 14, 2019, Dr. Coyle released Petitioner from care with a 30 lb. lifting restriction.

Rather than rely on Dr. Coyle's recommendations or send Petitioner back to Dr. Bernardi or any other surgeon, Respondent sent Petitioner to Physiatrist Wayne. He admitted that he had never performed a fusion surgery and that segments above and below Petitioner's fused spine were at risk of injury because of the extra pressure they would be under. Nevertheless, on three separate occasions in his deposition, Physiatrist Wayne, concluded that Petitioner could return to work without restrictions in May of 2019, less than 12 weeks after having undergone a two level fusion. Only on cross examination did he realize the imprudence of that opinion and he testified that Petitioner could return to work as an insulator without restrictions as of October 14, 2019. In my view, that opinion is equally misplaced.

Petitioner is an insulator in his mid-forties who has undergone a two-level lumbar fusion and worked extremely hard on his recovery. I would rely upon the opinion of the orthopaedic surgeon, Dr. Coyle, and find that Petitioner is unable to return to unrestricted duty as an insulator. I would have awarded maintenance benefits accordingly.

For all the foregoing reasons, I respectfully dissent from the decision of the majority.

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION **21IWCC0212**

NOTICE OF 19(b) ARBITRATOR DECISION

HENDERSON, JEFFERY MICHAEL Case# **18WC038045**

Employee/Petitioner

SAFEWAY SCAFFOLDING/SAFWAY SERVICES LLC

Employer/Respondent

On 4/16/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2204 THE UNSELL LAW FIRM PC
EDWARD W UNSELL
69 S 9TH ST
EAST ALTON, IL 62024

0265 HEYL ROYSTER VOELKER & ALLEN
TONEY TOMASO
PO BOX 1190
CHAMPAIGN, IL 61824-1190

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)

Jeffery Michael Henderson
Employee/Petitioner

Case # 18 WC 38045

v.

Consolidated cases: n/a

Safeway Scaffolding/Safway Services, LLC
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 cities of Herrin & Collinsville, on 1/15/2020 & 2/19/20, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 Rehabilitation Services**

FINDINGS

On the date of accident, October 26, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $32,691.57; the average weekly wage was $1,799.51.

On the date of accident, Petitioner was 44 years of age, married with 3 dependent child(ren).

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

Respondent shall be given a credit of $26,771.40 for TTD, $0.00 for TPD, $0.00 for maintenance, and $17,147.55 for other benefits, for a total credit of $43,918.95.

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner from October 26, 2018, through October 14, 2019, as identified in Petitioner's Exhibit 7 (excluding the bill for vocational services), as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Petitioner's Petition for prospective medical treatment is denied.

Respondent shall pay Petitioner temporary total disability benefits of $1,199.67 per week for 34 weeks, commencing November 14, 2018, through July 8, 2019, as provided in Section 8(b) of the Act.

Petitioner's Petition for maintenance benefits is denied.

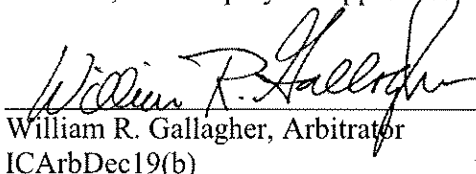
Petitioner's Petition for Sections 19(k) and 19(l) penalties and Section 16 Attorneys' Fees is denied.

Petitioner's Petition for vocational rehabilitation services 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)

April 7, 2020
Date

APR 1 6 2020

Evidentiary Ruling

Respondent had Petitioner examined by Dr. Andrew Wayne, a physiatrist, on November 25, 2019. Dr. Wayne was deposed on January 14, 2020. At that time and, at trial, Respondent's counsel tendered into evidence Dr. Wayne's medical report. On both occasions, Petitioner's counsel objected to the report being admitted into evidence on the basis of hearsay.

The hearsay objection was discussed/argued at length at trial. The Arbitrator reserved ruling on the hearsay objection and directed counsel for Petitioner and Respondent to further address the issue in their proposed decisions. However, this issue was not addressed in either proposed decision.

The Arbitrator has reviewed the deposition testimony of Dr. Wayne and considered the arguments made at trial by counsel. In that regard, counsel for Respondent argued that Dr. Wayne referenced the report when he was deposed so as to refresh his recollection and, because of this, the report is admissible. The Arbitrator notes that simply because Dr. Wayne made reference to the report in such a manner as to refresh his recollection does not cure a hearsay objection. Accordingly, the Arbitrator hereby sustains the hearsay objection of Petitioner's counsel. Dr. Wayne's report is not received into evidence.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on October 26, 2018. According to the Application, Petitioner sustained an injury "during the course of employment" and sustained an injury to his "back" (Arbitrator's Exhibit 2). Petitioner and Respondent stipulated Petitioner sustained a work-related accident on October 26, 2018, but Respondent disputed liability on the basis of causal relationship. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability and maintenance benefits as well as prospective medical treatment and vocational rehabilitation services (Arbitrator's Exhibit 1).

Petitioner claimed he was entitled to temporary total disability and maintenance benefits for 65 6/7 weeks, commencing November 14, 2018, through February 19, 2020 (final date of trial). Respondent claimed Petitioner was entitled to temporary total disability benefits of 29 5/7 weeks, commencing November 14, 2018, through June 9, 2019, and not entitled to any maintenance benefits (Arbitrator's Exhibit 1).

There was also a dispute regarding the computation of Petitioner's average weekly wage. Petitioner claimed he was entitled to an average weekly wage of $1,799.51 on the basis Petitioner was required by Respondent to work overtime hours. Respondent claimed Petitioner was entitled to an average weekly wage of $1,351.44 on the basis Petitioner was not required by Respondent to work overtime hours (Arbitrator's Exhibit 1).

Petitioner also filed a petition for Sections 19(k) and 19(l) penalties as well as Section 16 Attorneys' Fees. Respondent denied liability for same. (Arbitrator's Exhibit 1).

Petitioner was an insulator and worked out of a union hall. Petitioner began working for Respondent in July, 2018. The job was at the Phillips 66 refinery in Wood River and was a big job. When Petitioner was hired, it was his understanding the job would be 6/10s (six 10 hour days per week). For the first couple of weeks, which Petitioner referred to as "turnaround", Petitioner worked 40 hours per week. Afterward, Petitioner worked 6/10s until he sustained the accident on October 26, 2018.

Petitioner testified he was the general foreman and actually worked 6/11s. He stated the overtime hours were mandatory. Petitioner said that his acceptance of the job was voluntary, but once he did so, he was then obligated to work the 6/10s schedule. Specifically, Petitioner testified that he asked to take time off from work so he could attend his daughter's softball tournament, but this request was refused.

Following the accident of October 26, 2018, Petitioner was evaluated/treated by Dr. George Dirkers, Dr. Robert Bernardi and Dr. James Coyle. Dr. Coyle is an orthopedic surgeon and was Petitioner's primary treating physician. Ultimately, Dr. Coyle performed surgery on Petitioner's lumbar spine on February 11, 2019. The surgical procedure consisted of a laminotomy, foraminotomy and discectomy at L4-L5 and L5-S1, as well as a fusion at those levels with metal hardware and an iliac crest bone graft (Petitioner's Exhibit 1).

When Dr. Coyle initially saw Petitioner on November 9, 2018, he authorized Petitioner to work light duty/sedentary only. He subsequently authorized Petitioner to be off work completely on November 14, 2018 (Petitioner's Exhibit 2). That was when Respondent began paying Petitioner temporary total disability benefits. On November 14, 2018, Petitioner received a letter/document pertaining to a transitional duty assignment. It was signed by Pam Brangenberg, Respondent's Safety Manager. The letter described the transitional duty assignment as being temporary and would last until Petitioner returned to work to his regular duties, was at MMI or had exceeded 180 days for the injury. Apparently, because Petitioner was authorized to be off work by Dr. Coyle, he declined the offer (Petitioner's Exhibit 14). However, on direct examination, Petitioner testified he agreed to participate in the transitional duty program.

Subsequent to surgery, Dr. Coyle continued to treat Petitioner. He authorized Petitioner to return to work on May 17, 2019, with a 20 pound lifting restriction, no repetitive bending, stooping or twisting at the waist and no climbing ladders (Petitioner's Exhibit 2). Petitioner testified that sometime in late May, he was offered a light duty assignment by Respondent. Petitioner stated this was communicated to him by his attorney, but then said it was actually June, 2019.

Petitioner testified he lived in a remote area north of Alton, Illinois, and it was necessary to drive two hours from his residence to the refinery in Wood River. Because of the flooding which occurred in 2019, the bridge and ferry which connected the area where Petitioner lived were closed. As a result of this, Petitioner's drive would be approximately four hours.

Petitioner testified he did not report for light duty work in June, 2019, because of the time required to make the drive and Dr. Coyle had imposed a restriction of no sitting for longer than 30 minutes. Petitioner testified that on July 7, 2019, the ferry reopened. At that time, Petitioner said he called Pam Brangenberg, and left a voicemail message for her that it was his

understanding there was a light duty job and he was willing to attempt to return to work in that capacity. Petitioner stated Brangenberg did not return his call.

On cross-examination, Petitioner reviewed an e-mail dated June 6, 2019, from Respondent's counsel to Petitioner's counsel advising Petitioner was to report for work on June 10, 2019. Petitioner initially stated he did not recall seeing it, but later acknowledged it was something his attorney had provided to him. Petitioner also testified he did not report to work on June 10, 2019, because it was for a "sham job." Petitioner based this opinion on "Situational experience."

Petitioner also agreed on cross-examination that on June 11, 2019, he contacted Dr. Coyle's office and requested he provide him with a driving restriction. This was an action Petitioner undertook entirely on his own. Dr. Coyle declined to give Petitioner such a driving restriction with the only exception being when Petitioner was taking narcotic medication (Petitioner's Exhibit 4).

Petitioner acknowledged that he had been a union member for 23 years and his job had always required travel. He stated that the closest job he had ever been on was one and one-half hours away from his residence. For jobs which required more than four hours travel, Petitioner would many times obtain a hotel room. However, Petitioner declined to do so in June, 2019.

Petitioner also acknowledged that on March, 2019, approximately one month post-surgery, he was contemplating pursuing a different career. Petitioner's counsel referred him to Timothy Dolan, a vocational rehabilitation expert. Further, Petitioner applied for a job on June 3, 2019. The job application Petitioner tendered into evidence at trial was a generic job application so the Arbitrator was not able to determine who the prospective employer was or the nature of the job Petitioner was seeking (Petitioner's Exhibit 18).

As aforestated, Dr. Coyle was Petitioner's primary treating physician and he performed fusion surgery on Petitioner's low back on February 11, 2019. As previously noted herein, Dr. Coyle authorized Petitioner to return to work with restrictions on May 17, 2019. Dr. Coyle changed the restrictions on July 2, 2019, to no lifting over 30 pounds, intermittent sit, stand and walking every 30 minutes. These restrictions remained in place through October 14, 2019. At that time, Petitioner advised he had no pain when standing or lying, but had pain when sitting. Dr. Coyle ordered an MRI and EMG/nerve conduction studies. The diagnostic studies revealed no evidence of herniations or radiculopathy to explain Petitioner's continued symptoms. Dr. Coyle opined Petitioner was at MMI from a surgical point of view, but referred Petitioner to Dr. Patricia Hurford, a physiatrist, to see if anything could be done from a nonsurgical point of view (Petitioner's Exhibit 4).

Dr. Coyle was deposed on August 22, 2019, and his deposition testimony was received into evidence at trial. Obviously, this was two months prior to his finding Petitioner to be at MMI. On direct examination, Dr. Coyle's testimony regarding his diagnosis and treatment of Petitioner's low back condition was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Coyle described the surgery he performed on February 11, 2019, and that Petitioner did "very well" afterward (Petitioner's Exhibit 1; pp 16-18).

When Dr. Coyle saw Petitioner on July 2, 2019, Petitioner informed him he was "absolutely fine unless he sat." When Petitioner sat, he described his pain as being "terrible" and in the middle of his back. Following the appointment of July 30, 2019, Dr. Coyle ordered a CT scan. He testified "There is no indication whatsoever in the radiologist's report of any abnormalities or problems that would explain why Mr. Henderson couldn't sit." (Petitioner's Exhibit 1; pp 21-25).

At the time he was deposed, Dr. Coyle testified Petitioner was not at MMI, but was close. He noted Petitioner was walking seven miles a day, was not taking pain medication, was able to flex better than most people who never had a fusion, had excellent strength and had quit smoking. He noted Petitioner was 44 or 45 years old, but actually looked and seemed younger than that (Petitioner's Exhibit 1; pp 27-28).

On cross-examination, Dr. Coyle agreed he never imposed a restriction of Petitioner driving and specifically stated he did not tell Petitioner how long he could sit in a car. Further, Dr. Coyle agreed that if there was a restriction on the length of time Petitioner could drive, he would have so indicated that in his release (Petitioner's Exhibit 1; pp 45-47).

At the direction of Respondent, Petitioner was examined by Dr. Andrew Wayne, a physiatrist, on November 25, 2019. Dr. Wayne was deposed on January 14, 2020, and his deposition testimony was received into evidence at trial. In connection with his examination of Petitioner, Dr. Wayne reviewed medical records and the deposition testimony of Dr. Coyle which were provided to him by Respondent. Dr. Wayne's findings on examination were normal and he found no evidence of lumbar radiculopathy. He noted Petitioner complained of low back pain when sitting, but the EMG/nerve conduction studies and CT scan that were obtained by Dr. Coyle did not provide an explanation for Petitioner's complaints of low back pain while sitting (Respondent's Exhibit 1; pp 10-20).

Dr. Wayne stated that Dr. Coyle was not able to explain why Petitioner was experiencing pain when sitting. He also had no explanation for Petitioner having pain while sitting. Dr. Wayne testified there was no need to restrict Petitioner's sitting or any reason to restrict Petitioner's driving, other than those occasions when Petitioner was taking narcotic medication. He also noted Petitioner had a "magnified pain response" at the time of his examination (Petitioner's Exhibit 1; pp 25-29).

Dr. Wayne testified Petitioner had a stable fusion and could return to work without restrictions. He also stated there was no need for further medical treatment, including Petitioner being referred to a physiatrist. Dr. Wayne initially said the return to work date was May 17, 2019, but corrected this to October 14, 2019, when Dr. Coyle had found Petitioner to be at MMI (Respondent's Exhibit 1; pp 27, 32-39).

At trial, Don Van Horn testified on behalf of Petitioner. Van Horn was a coworker of Petitioner and his testimony was in regard to whether overtime hours were mandatory. Van Horn testified that if an insulator is hired to work 6/10s, it is mandatory and, if an employee declines to do so, he may be fired.

On cross-examination, Van Horn could not name an individual who had been fired because of refusing overtime hours. He agreed the individual could decline the job if he did not want to work overtime. However, on redirect, Van Horn stated that overtime is mandatory once a job is accepted.

Gerald Donovan also testified on behalf of Petitioner at trial. Donovan was the Union Business Manager. He stated that when a prospective employer contacts him, he is informed of the type of job, whether it is a 40 hour week, 6/10s, etc. He testified the individual can choose not to accept the job, but once he does accept the job, if it is scheduled as a 6/10s, working those hours is mandatory.

On cross-examination, Donovan agreed the union member can refuse to take a job which has overtime. He also stated that an individual having to drive two hours to get to a job was not unusual.

Mark Kuelsman testified for Respondent at trial. Kuelsman was Respondent's Insulation Construction Manager. Kuelsman's duties included contacting union halls and advising what work was available, how many workers were needed, etc. He testified the job Petitioner was hired to work at started as a 40 hour a week job, but transitioned to a 6/10s job. Kuelsman testified overtime was not mandatory because of provisions in the union contract/collective bargaining agreement. However, the union contract/collective bargaining agreement was not tendered into evidence at trial. Kuelsman stated some employees work overtime and others do not. He stated that if an employee declines overtime, no punitive action is taken against him.

On cross-examination, Kuelsman questioned whether he recalled Petitioner asking for time off to attend a softball tournament. Kuelsman recalled the conversation, but did not recall if Petitioner took off from work or not.

Pam Brangenberg testified for Respondent at trial. Brangenberg was the site Safety Manager. Her testimony focused on Respondent's light duty work program. She explained light duty positions vary depending on what the employee could do, their restrictions, etc. She was aware of the fact Dr. Coyle had performed back surgery on Petitioner and the work restrictions he had imposed. She testified Respondent had work which conformed to the restrictions and Petitioner was instructed to report for work on June 10, 2019, but did not do so. She testified that the light duty assignment still consisted of necessary tasks to be performed and took issue with Petitioner's assertion that the position offered to him was a "sham job."

Brangenberg was familiar with the area where Petitioner lived and did not dispute Petitioner's testimony regarding the travel time necessary to get from his residence to the refinery in Wood River. She also agreed the ferry and bridge Petitioner would usually use were closed for a period of time because of the flood.

Brangenberg testified she did receive a telephone call from Petitioner in which he left a message. She stated she contacted Respondent's counsel and, based on his advice, did not return Petitioner's call. However, on July 10, 2019, Respondent's counsel sent Petitioner's counsel an e-mail regarding Petitioner not reporting for work on June 10, 2019, the driving time issue,

Petitioner's claim the job was a "sham job" and that Respondent would not pay further temporary total disability benefits or authorize vocational rehabilitation (Respondent's Exhibit 6).

Petitioner testified it was his understanding that the restrictions imposed by Dr. Coyle on October 14, 2019, were permanent and he wants to proceed with further treatment as recommended by Dr. Coyle. He does not believe that he would be able to perform the job of an insulator and wants vocational rehabilitation services. After a rather prolonged period of cross-examination, Petitioner conceded that Dr. Coyle never restricted him from driving.

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, in part, causally related to the accident of October 26, 2018.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained an injury to his low back on October 26, 2018, which ultimately required fusion surgery at L4-L5 and L5-S1.

Petitioner claims his current condition of ill-being causes him to experience extreme pain symptoms in his low back when sitting. Both Petitioner's primary treating physician, Dr. Coyle, and Respondent's Section 12 examiner, Dr. Wayne, were unable to determine any explanation for Petitioner's ongoing symptoms. Dr. Wayne also noted signs of symptom magnification on examination.

Dr. Coyle opined Petitioner did very well following surgery, the fusion was solid, Petitioner walked seven miles a day, had good flexion, excellent strength and was in sound physical condition. Given the preceding, it is difficult for the Arbitrator to understand when he determined Petitioner to be at MMI; however, Dr. Coyle continued to impose work restrictions.

Given the preceding, the Arbitrator finds the opinion of Dr. Wayne that Petitioner can return to work without restrictions to be persuasive.

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

The Arbitrator concludes Petitioner had an average weekly wage of $1,799.51.

In support of this conclusion the Arbitrator notes the following:

The testimony of Petitioner, Don Van Horn and Gerald Donovan was consistent in that all of them testified overtime hours were mandatory. Further, Petitioner, Van Horn and Donovan explained that an individual had the prerogative of refusing to accept a job if there were overtime hours; however, once a job with overtime hours was accepted, the overtime hours were mandatory.

Respondent's witness, Mark Kuelsman testified overtime hours were not mandatory and, he based this on the union contract/collective bargaining agreement. However, the union contract/collective bargaining agreement was not tendered into evidence at trial.

Based upon the preceding, the Arbitrator finds overtime hours were mandatory and are to be included in the computation of the average weekly wage. *Edward Hines v. Industrial Commission*, 575 N.E.2d 1234 (Ill. App. 1st Dist. 1990).

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner from October 26, 2018, through October 14, 2019, was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from October 26, 2018, through October 14, 2019, as identified in Petitioner's Exhibit 7 (excluding the bill for vocational services), 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 not entitled to prospective medical treatment.

In support of this conclusion the Arbitrator notes the following:

As noted in disputed issue (F), Dr. Coyle had no explanation for Petitioner's continued complaints and he opined Petitioner was at MMI, but referred him to Dr. Patricia Hurford.

Respondent's Section 12 examiner, Dr. Wayne, opined further medical treatment was not necessary.

The Arbitrator is persuaded by the opinion of Dr. Wayne that Petitioner does not need prospective medical treatment.

In regard to disputed issue (L) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 34 weeks, commencing November 14, 2018, through July 8, 2019.

The Arbitrator concludes Petitioner is not entitled to maintenance benefits.

In support of these conclusions the Arbitrator notes the following:

The Arbitrator acknowledges that, at the time the offer of light duty work was initially made to Petitioner in June, 2019, it would have been overly burdensome for Petitioner to travel to/from

his residence and the refinery in Wood River. This was because of the closure of the ferry and bridge which was caused by the flood. At that time, Petitioner was not at MMI and was still being treated by Dr. Coyle.

As of July 9, 2019, the bridge and ferry were re-opened and Petitioner could have made the trip to/from his residence and the refinery in Wood River.

Petitioner's refusal to even attempt to return to work to a light duty assignment on the basis that the job was a "sham job" was based solely on Petitioner's "Situational experience." The Arbitrator finds this is not a basis to refuse an offer of light duty work.

Respondent's Safety Manager, Pam Brangenberg credibly testified regarding the specifics of Respondent's light duty work program.

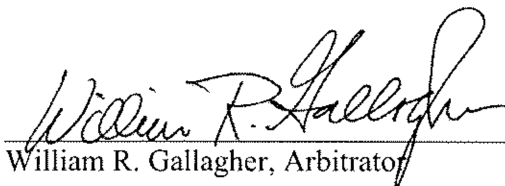
The Arbitrator also notes Petitioner apparently decided to seek other work as early as March, 2019, approximately one month post-surgery and long before he was found to be at MMI. Petitioner also applied for a job on June 3, 2019. The preceding causes the Arbitrator to have some doubts as to Petitioner's credibility.

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

Based upon the preceding conclusions of law, the Arbitrator concludes Petitioner is not entitled to Sections 19(k) and 19(l) penalties or Section 16 Attorneys' Fees.

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

Based upon the preceding conclusions of law, the Arbitrator concludes Petitioner is not entitled to vocational rehabilitation services.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC017839
Case Name	MONTOYA, JUAN v. J & R DAIRY INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0213
Number of Pages of Decision	21
Decision Issued By	Deborah L. Simpson, Commissioner

Petitioner Attorney	RAYMOND M. SIMARD
Respondent Attorney	Ron March

DATE FILED: 4/29/2021

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

Juan Montoya,
Petitioner,

vs. NO: 18 WC 17839

J & R Dairy Inc,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020, is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court 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: 4/29/2021
o4/7/21
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0213
NOTICE OF ARBITRATOR DECISION

MONTOYA, JUAN
Employee/Petitioner

Case# **18WC017839**

J & R DAIRY INC
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

0210 GANAN & SHAPIRO PC
RONALD MARCH
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

Juan Montoya
Employee/Petitioner

Case # **18** WC **017839**

v.

Consolidated cases: **NA**

J & R Dairy Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah J. Baker**, Arbitrator of the Commission, in the city of **Chicago**, on **February 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 7, 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**27,460.00**; the average weekly wage was $**1,193.93**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

Petitioner proved that on June 7, 2018, at the time of the left leg injury, an employee/employer relationship existed between him and Respondent.

Petitioner failed to prove he sustained accidental injuries arising out of his employment by Respondent.

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

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

Signature of Arbitrator

April 13, 2020
Date

APR 14 2020

FINDINGS OF FACT

Testimony of Juan Montoya

On June 7, 2018, Juan Montoya ("Petitioner") was a thirty-two-year-old delivery truck driver and was married with two dependent children under the age of eighteen. (Tr. 18; Arb.'s Ex. 1.) At the arbitration hearing, Petitioner testified that on June 7, 2018, he worked for J & R Dairy ("Respondent") located in Bridgeview, Illinois, as a delivery truck driver and he drove semi-tractor-trailers/eighteen-wheelers. (Tr. 12.) Petitioner testified that before June 7, 2018, he was employed by Respondent. (Tr. 66.) Petitioner testified that Respondent hired him as a delivery truck driver for approximately seven years, but he eventually left the company. (Tr. 66.) Respondent rehired Petitioner on September 28, 2015 and Petitioner already knew how to do the job of a driver when he was rehired. (Tr. 48, 66-67.)

Petitioner testified that a typical workday began between 5:30 a.m. and 6:00 a.m. (Tr. 35.) The time that Petitioner ended work would vary depending on the weather and traffic but was usually between 3:30 p.m. and 4:00 p.m. (Tr. 35.) Petitioner testified that his job duties included either doing "hauls" or delivering dairy product to grocery stores. (Tr. 12.) Petitioner explained that to complete a "haul" he would leave Respondent's facility in Bridgeview with an empty trailer and drive to the Dean Foods warehouse in Huntley, Illinois. (Tr. 12.) Once there, Petitioner testified he would pick up a pre-loaded trailer with milk and take it back to Respondent's facility in Bridgeview. (Tr. 13.) Petitioner testified that when he returned to Bridgeview, his practice was to park the trailer, make sure the load was fine, and make sure that the tractor and trailer were fine. (Tr. 17.) If he planned to do another haul, he would pick up another empty trailer, and head out to Huntley, Illinois again. (Tr. 17.) If it was the last haul of the day, he had to do a "post-trip" inspection. (Tr. 17.) Petitioner explained that a "post-trip" meant: "I have got to make sure that everything in the department is properly fine before I leave the warehouse [sic]." (Tr. 17.) Petitioner testified he would complete the same roundtrip three times per day when he did hauls. (Tr. 13.)

Petitioner testified that approximately two weeks before June 7, 2018, he gave Ross Purpura, Sr. ("Ross, Sr."), Respondent's owner, notice of his intended resignation in two weeks. (Tr. 13.) His last scheduled date of employment with Respondent was June 7, 2018. (Tr. 13-14.) Petitioner had a four-day trip to Las Vegas scheduled for June 8, 2018 through June 11, 2018 and had already bought airline tickets. (Tr. 14-16.) Petitioner planned to begin working for Breakthru Beverage, a liquor distributor, on June 12, 2018. (Tr. 14-15.)

Petitioner testified that on June 7, 2018, he completed three hauls. (Tr. 18.) Petitioner testified that on his third and last haul, before he left Dean Foods in Huntley, Illinois, he inspected his truck load, which he was required to do. (Tr. 26.) Petitioner testified that the load was secure before he left Huntley. (Tr. 26, 44.) Petitioner also testified that there were no straps, no miscellaneous items, and no loose gallons of milk lying around when he checked the trailer. (Tr. 45.) At the end of the third and last haul, Petitioner backed his trailer into a dock at Respondent's facility and took the paperwork that he had received in Huntley out of the truck. (Tr. 18.) Petitioner testified that he arrived at Respondent's facility between 3:30 p.m. and 4:00 p.m. (Tr. 36.) Petitioner testified further that after he got out of the truck, he went to the office

and gave his paperwork to "Dave," the foreman at Respondent's facility. (Tr. 18-19.) Petitioner testified that he said goodbye to "the girls" that worked in the office and then began to do his "post-trip" of the trailer in the dock area of Respondent's facility. (Tr. 19, 61-62.)

Petitioner testified that he performed his post-trip, which included checking the side door of the trailer. (Tr. 19.) Petitioner testified that when he checked the side door of the trailer, he noticed that the bar (the loader) that holds the load up was off. (Tr. 19.) Petitioner testified that he climbed into the trailer, as he had done many times before, and put the bar back on. (Tr. 19.) Petitioner testified further that "when I came back to come off, I swinged [sic] my left leg and my right leg got caught up on a pallet, I'm guessing, or on a nail or something - - ." (Tr. 19.) Petitioner testified that he climbed out of the trailer facing outside the trailer. (Tr. 22.) Petitioner testified that when his right leg got caught, his instinct was to "push off; and that's when I landed on my left leg and I heard a snap…" (Tr. 19-20.) When asked whether he jumped or fell, Petitioner testified "It's kind of an awkward thing. It's like I kind of pushed off myself because this leg got stuck. So it's kind of a jump off like fell off type because this one got stuck, so I was trying to unhook it to get off; and that's when I fell on my left leg." (Tr. 33.) Petitioner testified that he landed on asphalt. (Tr. 33.) Petitioner testified that he experienced excruciating pain in his left leg after he hit the ground. (Tr. 21.) Petitioner could not recall if he spoke to anyone immediately after his injury although he recalled that there were some people around him. (Tr. 23.) Petitioner denied giving any oral or written statements to anyone with Respondent on that day. (Tr. 24.) Petitioner testified that he was transported to the hospital by ambulance. (Tr. 27.)

Petitioner reviewed a video marked as Respondent's Exhibit Twelve (RX12) and testified that it showed Ross Purpura Jr. ("Ross, Jr.") getting in and out of a trailer. (Tr. 21-22.) Petitioner testified that the video did not reflect how he would normally get in and out of the side door of a trailer. (Tr. 22.) The video showed Ross, Jr. walking up and down the steps facing inside the trailer and he never faced forward (faced outside the trailer) like Petitioner had when he climbed out of the trailer on June 7, 2018. (Tr. 22.)

Petitioner testified that On June 7, 2018, had he not injured himself, he still would have had to log-off an application using his personal phone, unhook the trailer, park the tractor close to his personal vehicle, and then leave in his personal vehicle. (Tr. 20.) Petitioner testified that at the time he fell, he had not logged off and had not unhooked the tractor from the trailer. (Tr. 20-21.) Petitioner testified further that on June 7, 2018, he did not try to steal two gallons of milk from Respondent. (Tr. 24.) In reviewing the first of two photographs marked as Respondent's Exhibit Fourteen (RX14), Petitioner testified that the trailer in the photographs was not his trailer because his trailer did not have a two-wheel hand truck (also known as a "hand truck" or "hand cart") in it. (Tr. 25.) Petitioner testified that hand trucks are not used during hauls and Petitioner is not required to do any loading or unloading during hauls, for which he would use a hand truck. (Tr. 25-26.) Additionally, Petitioner testified that when he had inspected his trailer prior to leaving Huntley for the third and last time on June 7, 2018, there was no hand truck in the trailer. (Tr. 26.) Petitioner also testified that his trailer had milk on both sides. (Tr. 26-27.) Petitioner testified that excluding the hand truck and the milk, the pictures depicted how his trailer looked on June 7, 2018. (Tr. 25-27.)

Petitioner testified that he never returned to work for Respondent. (Tr. 30.) After

undergoing medical treatment and being released to full duty work, in March 2019, Petitioner began working for a liquor distributor delivering wine and spirits for approximately one month. (Tr. 30-31.) Petitioner testified that afterward, he found a position with the City of Chicago as a general laborer behind a garbage truck where he works currently. (Tr. 31.) Petitioner testified that he currently works forty hours per week and he is on his feet all day in all types of weather. (Tr. 31-32.) Petitioner testified that his left leg hurts every day. (Tr. 32.) Petitioner testified that his left leg gets tired more and swells from the left knee to his toes almost every day. (Tr. 32-33.) Petitioner testified that when he gets home from work he elevates his left leg, takes Tylenol and puts "Biofreeze" on it. (Tr. 33.) Petitioner denied having injured his left leg either prior to or after June 7, 2018. (Tr. 33.)

On cross examination, Petitioner testified that when he arrived at Respondent's facility in Bridgeview, he drove through a gate. (Tr. 36.) Petitioner reviewed a photograph marked as Respondent's Exhibit Five (RX5), and testified that it showed 76th Street, which leads to the driveway you have to take to get to the entrance of Respondent's facility. (Tr. 37.) Petitioner testified that the photograph showed the gate that he would drive through when entering Respondent's facility. (Tr. 37.) Petitioner reviewed a photograph marked as Respondent's Exhibit Six (RX6) and testified that it showed the parking area where Respondent's employees parked. Petitioner testified that the employee parking area is outside of the fence and gate that closes off Respondent's facility. (Tr. 38.)

Petitioner testified that on June 7, 2018, he only parked the truck cab (tractor) in the area where the employee vehicles were parked. (Tr. 39.) The trailer had already been backed into the dock at the facility. (Tr. 39.) Petitioner did not recall hearing Ross, Jr. tell him that Ross, Jr. would disconnect the trailer and unload it on June 7, 2018. (Tr. 40.) Petitioner reviewed a photograph marked as Respondent's Exhibit Eight (RX8), and testified that it showed the side of a tractor-trailer and was similar to the type of eighteen-wheeler that Petitioner drove for Respondent. (Tr. 40.) Petitioner reviewed a photograph marked as Respondent's Exhibit Thirteen (RX13) and testified that it showed an overhead view of Respondent's facility. (Tr. 41.) Petitioner acknowledged that the photograph showed the driveway that leads to the gated entrance of Respondent's facility and also showed the docking station at Respondent's facility. (Tr. 41.)

When asked whether his children drink milk, Petitioner testified that they occasionally drink milk. (Tr. 43.) When asked if he ever gave his children two percent Dean's milk as depicted in the photographs that he reviewed, Petitioner said no. (Tr. 43.) Petitioner stated: "Well, when they were growing up probably as they are babies probably because the doctor will tell them. Other than that, they always drink whole milk at home." (Tr. 43-44.)

Petitioner testified that at the end of the day on June 7, 2018, he spoke with an individual named Dave Callahan ("Callahan") who was a foreman. (Tr. 46.) Petitioner testified that on that day, he gave Callahan the paperwork from his last haul and any company items that were in his possession. (Tr. 46.) Petitioner testified that he did not receive a paycheck on June 7, 2018 at the end of the day. (Tr. 47.) Petitioner testified that on a subsequent date, Petitioner's wife drove him to pick up his last paycheck. (Tr. 47.) Petitioner testified that on the day he picked up his last paycheck, he called Callahan from his vehicle and Callahan walked out of the facility and

gave Petitioner his final check. (Tr. 48.) Petitioner could not recall the exact date that he picked up his final check, however, it was no more than one month after June 7, 2018. (Tr. 47-48.)

Petitioner testified that when he was rehired on September 28, 2015, he never went through orientation and nobody informed him of Respondent's policies and procedures. (Tr. 49-51.) Petitioner testified that that he was not aware of a policy that drivers are not supposed to be in the trailers after they dock a trailer at Respondent's facility. (Tr. 51.) Petitioner testified that he had unloaded trailers at Respondent's dock in the past with Ross, Jr. present. (Tr. 51.) When asked if he jumped out of his trailer on June 7, 2018, Petitioner responded, "Yeah, pushed myself off." (Tr. 53.)

With respect to RX12 and getting in and out of the trailer, Petitioner testified that it is proper to get in and out of the trailers using the steps. (Tr. 54-55.) Petitioner acknowledged that jumping from the trailer, approximately five feet, would be extremely risky. (Tr. 55.) Petitioner testified that he was aware that Respondent's policy prohibited jumping out of the trailer. (Tr. 55.) Petitioner testified that he did not recall speaking to "Norm Frey" and did not know who "Norm Frey" was. (Tr. 56.) Petitioner testified that he remembered somebody found him on the ground after his injury but he did not know the person's name. (Tr. 56.) Petitioner testified that he would recognize "Norm Frey" by his face or physically but he did not know his name. (Tr. 57.) Petitioner did not recall telling "Norm Frey" that he jumped out of the trailer. (Tr. 57.) Petitioner recalled that Ross, Jr. arrived soon after his injury, before the paramedics arrived. (Tr. 58.)

On redirect examination, Petitioner testified that on June 7, 2018, he did not plan to jump out of the trailer and he did not normally jump. (Tr. 59.) Petitioner testified that he planned to use the steps to get out of the trailer. (Tr. 60.) With respect to his paychecks, Petitioner testified that Respondent normally paid him on Fridays and he was paid for the previous week of work. (Tr. 60.) In reviewing RX5, Petitioner testified that at the gated entrance to Respondent's facility, there is a guard. (Tr. 62.) Petitioner also testified that there is a security camera at the top of the guard shack. (Tr. 62.) Petitioner testified that if he was convicted of a misdemeanor for theft, he would have been terminated from the job that he planned to start on June 12, 2018. (Tr. 64-65.) Petitioner testified that on June 7, 2018, Ross, Jr. probably unhooked the trailer that Petitioner brought in and parked the trailer because Petitioner could not have done it due to his injury. (Tr. 65.) Petitioner testified that normally, he would park the tractor after it was unhooked from the trailer. (Tr. 65.)

Testimony of Ross Purpura, Sr.

Ross Purpura, Sr. ("Ross, Sr."), is Respondent's co-owner and president, and he has had ownership of the company since 2000. (Tr. 71-74.) Ross, Sr. testified that his son, Ross, Jr., also works for Respondent. (Tr. 73.) Ross, Sr. testified he oversaw all operations for Respondent. (Tr. 74.) Ross, Sr. testified Respondent is a wholesale distributor of dairy products to grocery stores. (Tr. 74.) He testified he employs truck drivers (who also operate as delivery drivers), dock workers, and office personnel. (Tr. 75.) Ross, Sr. testified drivers do deliveries and hauls. (Tr. 75.) He testified deliveries involve taking dairy products to grocery stores. (Tr. 75.) Ross, Sr. testified hauls involve a driver picking up a load of milk in Huntley, Illinois, and bringing the trailer back to Respondent's facility in Bridgeview. (Tr. 76.) He testified that the

drivers drive eighteen-wheelers. (Tr. 76.) Ross, Sr. testified most of his drivers do both delivery routes and hauls in the same day. (Tr. 76.)

Ross, Sr. testified that there is a strict company policy against letting drivers load or unload a truck in the dock area. (Tr. 78-79.) When a driver backs into the docking area, the tractor and trailer are left hooked up so that dock workers can unhook and unload the trailer. (Tr. 78.) Ross, Sr. testified that this policy is in place for safety reasons. (Tr. 78.) Ross, Sr. testified that once a driver backs into the dock, the driver should have no further contact with the vehicle. (Tr. 81.) Ross. Sr. also testified that drivers are prohibited from being in the dock area and from being in the trailers to do loading and unloading. (Tr. 88-89.) The only people who could provide authorization for a driver to be in the trailer after it was docked is Ross, Sr. or Ross, Jr. (Tr. 89.) Ross, Sr. testified that he never authorized Petitioner to be on the trailer on June 7, 2018. (Tr. 91.)

Ross, Sr. testified that he took the pictures submitted into evidence as Respondent's Exhibits Two (RX2), Three (RX3), Four (RX4), Five (RX5), Six (RX6), Seven (RX7), Eight (RX8), and Thirteen (RX13). (Tr. 81-83.)

Ross, Sr. testified to the following:

- RX2 – the second photograph depicts the driver "check-in window." (Tr. 84.) This is where the drivers would pick up their assignments and paperwork at the beginning of the work day and would turn in their paperwork at the end of the work day. (Tr. 84-85.)
- RX3 – the photograph depicts the hallway leading out from the driver's "check-in" area leading to the dock area or the office. (Tr. 86.) The window looking into the office is to the left of the photo. (Tr. 86.)
- RX4 – the photograph depicts the dock area that driver's enter from the hallway which driver's walk through to "check-out" at the window. (Tr. 87.) The loading area is to the right of the photo and driver's are prohibited from being in this area. (Tr. 87.) The driver's leave the facility where it says "exit." (Tr. 87.)
- RX5 – the photograph depicts the gate at the entrance of Respondent's facility. (Tr. 82.)
- RX6 – the photograph depicts the parking area where the truck drivers, such as Petitioner, would park their personal vehicles. (Tr. 83.)
- RX7 – Ross, Sr. did not describe the photograph
- RX8 – the photograph depicts the side of a "Dean's truck." (Tr. 88.)
- RX13 – the Google image of Respondent's facility depicts how Respondent's facility looked on June 7, 2018. (Tr. 79.)

Ross, Sr. reviewed Respondent's Exhibit One (RX1) and testified that he recorded the video. (Tr. 97-98.) Ross, Sr. testified that it is his voice recording on the video. (Tr. 98.) Ross, Sr. testified that the video shows the following: The video begins by looking through a window into the driver's room where Callahan's office is located. (Tr. 99-100.) The video then moves through a hallway, showing the route a driver would take to exit the facility through a dock door. (Tr. 100.) The loading area is through a dock door to the right and there are yellow lines to the

right. (Tr. 100.) The lines are used to show the area where non-dock workers are prohibited. (Tr. 100.) The video then proceeds through the door, where drivers exit the building. (Tr. 101.) The camera turns to the left to head through the gate toward the employee vehicles. (Tr. 101.)

Ross, Sr. reviewed Respondent's Exhibit Twelve (RX12) and testified that he recorded the video. (Tr. 105.) Ross, Sr. testified that the video showed the proper way to climb in and out of a trailer. (Tr. 106.) Ross, Sr. testified that the individual in the video is Ross, Jr. and testified that the approximate height from the trailer lip to the ground is four-and-a-half feet to five feet. (Tr. 107.) He testified that drivers are prohibited from jumping out of trailers because they can get hurt. (Tr. 107.) Ross, Sr. testified all employees are instructed not to jump out of a truck or trailer. (Tr. 107.)

Ross, Sr. testified he knew Petitioner. (Tr. 107.) He testified Petitioner was hired as a route driver and he had no loading and unloading duties. (Tr. 90-91.) When asked if Petitioner was given any type of orientation when he was rehired on September 28, 2015, Ross, Sr. testified that Petitioner was given a "quick refresher" and he thought that he (Ross, Sr.) was the one who gave Petitioner the refresher. (Tr. 91-92.) Ross, Sr. testified that he would have given Petitioner a "quick overview of safety." (Tr. 92.) Ross, Sr. testified Petitioner's work day began at 5:30 a.m. and ended between 3:30 p.m. and 4:30 p.m. (Tr. 93.)

Ross, Sr. testified Petitioner gave him notice of his intent to terminate his employment. (Tr. 93.) He testified Petitioner's last day of work was to be June 7, 2018. (Tr. 93.) Ross, Sr. testified that the protocol for Petitioner upon returning with his last haul on June 7, 2018, would have been to take whatever personal items Petitioner had in the truck cab and all of the paperwork for the day, and give it to Callahan. (Tr. 93.) Ross, Sr. testified that after Petitioner turned in his company items and paperwork for the day, Petitioner had no other duties or responsibilities to perform. (Tr. 94.) Ross, Sr. believed that Petitioner was given a paycheck on June 7, 2018. (Tr. 94.) Ross, Sr. instructed Callahan to give Petitioner a paycheck on June 7, 2018 because it was Petitioner's last day working for Respondent. (Tr. 95.) Ross, Sr. testified that in his opinion, Petitioner no longer worked for Respondent once Petitioner received his paycheck. (Tr. 95-96.)

Ross, Sr. testified that on June 7, 2018, Petitioner had started with a delivery route and finished by picking up a haul in Huntley. (Tr. 77.) In reviewing RX3, Ross, Sr. testified that on June 7, 2018, Petitioner "checked out" at the end of his workday at the window with Callahan, who is a foreman and the night supervisor. (Tr. 85.) Ross, Sr. testified that Ross, Jr. was responsible for unloading Petitioner's trailer on that day. (Tr. 81.)

On cross-examination, Ross, Sr. testified that in the video, Ross, Jr. never stepped inside the trailer before climbing back down the steps. (RX12; Tr. 108.) Ross, Sr. testified that all of his trucks are subject to Department of Transportation ("DOT") regulations including safety regulations. (Tr. 112.) Ross, Sr. acknowledged that if Petitioner received a check on June 7, 2018, it would have been for the previous week of work. (Tr. 113.) Ross, Sr. testified that he did not believe that any reports were completed with respect to the June 7, 2018 incident besides the Form 45. (Tr. 117.)

In reviewing RX5, Ross, Sr. testified that there is a guard shack near the gate. (Tr. 117.) Ross, Sr. testified that the camera above the guard shack and all the cameras on the property, were not operating and were not "hooked up" on June 7, 2018. (Tr. 117-118.) Ross, Sr. testified that he does not know whether his employees are aware that the cameras are not operating, however, he has never told them this. (Tr. 118.)

In reviewing RX14 (two photographs), Ross, Sr. testified that the reason a hand truck is in the photos is that Petitioner would need a hand truck to make deliveries. (Tr. 12.) Ross, Sr. testified that on June 7, 2018, Petitioner made deliveries first and then ended the day by making a haul. (Tr. 120.) Ross, Sr. testified that he did not keep the paperwork which would show whether and how many hauls that Petitioner made that day. (Tr. 120-121.) Ross, Sr. testified that Petitioner would not have had to "punch in" or "punch out" because he and the other drivers were salaried. (Tr. 122.)

On redirect examination, Ross, Sr. testified that two-wheel hand carts (as seen in RX14) are in the trailers when drivers return from their delivery routes. (Tr. 124.) If Petitioner was doing hauls on June 7, 2018, there would not have been a two-wheel hand cart in the trailer. (Tr. 124.)

Testimony of David Callahan

Callahan testified he was appearing under subpoena. (Tr. 127.) Callahan testified that on June 7, 2018, he was employed by Respondent. (Tr. 127.) He testified that he now works for a different company. (Tr. 127.) Callahan testified that while employed by Respondent, he was in charge of maintenance of the fleet of trucks. (Tr. 127.) Callahan testified that at the end of the day, all drivers checked in with him and gave him their paperwork, computers, "handhelds," etc. (Tr. 127.) Callahan testified he was also responsible for closing the building at night. (Tr. 127.)

Callahan testified Petitioner was a driver for Respondent. (Tr. 127-128.) He testified that Petitioner's duties consisted of making deliveries to stores and picking up hauls at Dean Foods in Huntley, Illinois. (Tr. 128.) Callahan testified that sometimes drivers would do deliveries and then pick up a load in Huntley to bring back to Respondent's facility. (Tr. 128, 131.) Callahan testified when a driver arrived at the facility at the end of the day with a haul, the driver would back into the dock and then check-in with him. (Tr. 129-130.)

Callahan testified he did not recall what time Petitioner returned to the facility on June 7, 2018. (Tr. 130.) Callahan testified he recalled Petitioner coming to see him when Petitioner returned at the end of the day on June 7, 2018. (Tr. 130.) Callahan testified Petitioner told him it was Petitioner's last day working for Respondent. (Tr. 130.) Knowing this, Callahan testified he collected everything needed from Petitioner, which included Petitioner's gas card, fuel card, handheld, and printer. (Tr. 131.) Callahan testified he gave Petitioner his paycheck "for that week." (Tr. 131.) Callahan testified that at this point he considered Petitioner's employment to be finished. (Tr. 132.) Callahan testified that approximately fifteen to twenty minutes after Petitioner left his office, he was informed that Petitioner had hurt himself and that Petitioner was on the ground between two trailers. (Tr. 133-134.)

Callahan testified he went to the scene of the incident at the end of the day and by that time nobody was at the scene. (Tr. 134.) Callahan testified that when he went to the scene of the incident, he saw the trailer side doors were open. (Tr. 135.) He also noticed a "couple" gallons of milk sitting in the door and he pushed them back so that he could close the door. (Tr. 135.) Callahan testified he did not know why the milk was there. (Tr. 135.) Callahan testified he did not notice anything wrong at the entry of the side doors and he had no problems latching the doors. (Tr. 135.) He testified he did not see any loose straps in the trailer. (Tr. 136.)

On cross examination, Callahan testified that on some days, Petitioner would do three hauls in one day. (Tr. 137.) Callahan testified workers often left doors open or doors became unlatched. (Tr. 141.) He testified drivers doing hauls would sometimes be asked to pick up hand-trucks left behind in Huntley. (Tr. 142.)

Testimony of Norman Frey, Jr.

Norman Frey, Jr. ("Frey") works for Joe & Ross Ice Cream[1] as an ice cream route salesman. (Tr. 144.) Frey testified that he worked in that position on June 7, 2018. (Tr. 144.) Frey testified that on June 7, 2018, he returned from making his deliveries for the day around 3:00 p.m. (Tr. 145.) Frey testified that as he walked to the building to turn in his paperwork, he heard someone calling for help. (Tr. 146.) At first, he did not see anyone and thought that someone was "horsing around." (Tr. 146.) He eventually saw Petitioner on the ground on his back, screaming for help, between two trailers that were parked at the dock. (Tr. 146.) Frey testified that he asked Petitioner what happened and specifically asked Petitioner if he fell out of the truck or if he jumped out of the truck. (Tr. 146-147.) Frey testified "[h]e told me he jumped out of the truck." (Tr. 147.) Frey testified that he asked Petitioner why he did that and told him that he should not "be doing that kind of stuff." (Tr. 147.) Frey testified that he left to get his phone so that he could call 911 but, on his way, he ran into another coworker and asked that coworker to call 911. (Tr. 147.) Frey testified that he kept talking to Petitioner to keep him calm until the ambulance arrived. (Tr. 148.) It was at that time Petitioner told him it was his last day working for Respondent. (Tr. 148.)

Frey testified the proper procedure for getting out of a trailer is to use the steps. (Tr. 147.) Frey testified that the distance from where you stand on the trailer to the ground is about four-and-a-half feet to five feet. (Tr. 149.) Frey testified that he glanced inside the trailer while he was standing with Petitioner and when asked what he saw, he stated, "Not much. It was a pretty clear floor. I didn't really see anything of note, to be honest." (Tr. 149.)

In reviewing RX14, Frey testified that there were plenty of empty milk crates in the trailer but there was nothing laying on the floor. (Tr. 152.) Frey testified that the hand cart was likely in the trailer because that is something you would typically see in a milk truck; however, he did not remember seeing it specifically. (Tr. 151.) Frey stated that the empty pallets were inside the trailer. (Tr. 151.) Frey stated that he did not see two gallons of milk in the trailer. (Tr. 151.)

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[1] Based on Frey's testimony, it appears that Joe and Ross Ice Cream is a separate company owned by Ross Purpura, Sr. that operates out of the same facility that Respondent, J & R Dairy, operates out of in Bridgeview, Illinois.

On cross examination, Frey testified that Petitioner told him that Petitioner had jumped. (Tr. 153.) Frey testified: "I asked him if he jumped or he fell. He said, I jumped. I asked him why he did that. He said, I don't know. That was stupid. I don't know." (Tr. 153.) Frey testified that he gave a statement to someone from the "insurance company" about the incident. (Tr. 153.) When asked about what he noticed in the trailer Frey testified that he did not climb inside the trailer to look around and he did not inspect the trailer. (Tr. 154.) Frey testified that his view of the trailer was of the place where you would come down from. (Tr. 154.) Frey testified that when the paramedics arrived, there were approximately ten people at the scene of the incident, including Ross, Jr. (Tr. 155.)

On redirect examination, Frey testified that he spoke to the paramedics when they arrived and when the paramedics asked him what happened, Frey told the paramedics that Petitioner jumped out of the truck. (Tr. 156.)

Testimony of Ross Thomas Purpura, Jr.

Ross Thomas Purpura, Jr. ("Ross, Jr.") is employed by Respondent as a salesman. (Tr. 157-158.) Ross, Jr. testified that on June 7, 2018, he was employed by Respondent as dock foreman. (Tr. 158.) Ross, Jr. testified his duties as dock foreman were to unload and load all product. (Tr. 158.) More specifically, he testified a driver brings back a trailer, leaves it in the dock, and then Ross, Jr. tells the driver what dock to park it in. (Tr. 158.) Ross, Jr. testified he would then unload everything and park the trailer. (Tr. 158.) Ross, Jr. testified dock workers are responsible for loading the trucks with product and drivers are only supposed to bring the trailers to the dock for the dock workers and Ross, Jr. to unload. (Tr. 159.) He testified that Respondent had a strict policy of not allowing drivers to unload trailers at the facility for safety reasons. (Tr. 159.)

Ross, Jr. testified that Petitioner is a former driver for Respondent. (Tr. 160.) Ross, Jr. testified that he (Ross, Jr.) worked on June 7, 2018. (Tr. 160.) Ross, Jr. testified that he saw Petitioner for the first time that day between 3:30 p.m. and 4:00 p.m. (Tr. 160.) Ross, Jr. testified Petitioner pulled the trailer into the facility, and Ross, Jr. instructed Petitioner to park the trailer in Dock One and leave it there, because Ross, Jr. would "take care of the rest." (Tr. 160.) Ross. Jr. testified once the trailer was backed into Dock One, Petitioner did not have any other responsibilities with reference to the trailer. (Tr. 161.) Ross, Jr. testified Petitioner then walked towards the office. (Tr. 161.) Ross, Jr. testified that he inspected the trailer when Petitioner first pulled into the dock and he did not see any gallons of milk on the ground at that time. (Tr. 161-162.) Ross, Jr. testified he saw a hand-truck inside the trailer. (Tr. 162.) He testified it was normal to see hand-trucks and pallets in the trailers when drivers returned. (Tr. 162.) Ross, Jr. testified Petitioner would have inspected the trailer in Huntley before returning with a haul. (Tr. 163.) He testified this was done to make sure that the bars "and everything" were set up correctly so the milk did not fall. (Tr. 163.) Ross, Jr. testified there were no straps in the truck. (Tr. 164.)

Ross, Jr. testified he next saw Petitioner between 4:00 p.m. and 4:30 p.m. (Tr. 164.) Ross, Jr. testified that he arrived at the scene of the incident before the paramedics arrived and he

saw Petitioner on the ground with a broken leg. (Tr. 164-165.) He testified "Norm, Jr." was present. (Tr. 171.) Ross, Jr. testified he did not talk to Petitioner at the time of the incident. (Tr. 165.) Ross, Jr. testified he moved the trailer out of the dock at the paramedics' request so the paramedics could pick Petitioner up. (Tr. 165.) Ross, Jr. testified he did not touch anything on the inside of the trailer while moving it. (Tr. 166.) Ross, Jr. testified that once Petitioner had been moved by paramedics, he (Ross, Jr.) moved the trailer back to the same spot. (Tr. 166.)

In reviewing the two photographs marked as RX14, Ross, Jr. testified that he was responsible for taking the two photographs of the inside of the truck. (Tr. 166.) He testified he took the pictures on June 7, 2018. (Tr. 169.) Ross, Jr. testified that in his opinion, the photos showed that Petitioner took two gallons of milk from the top of a stack and put them on the floor of the trailer with the intent to jump out of the trailer and take the two gallons of milk with him. (Tr. 167.) Ross, Jr. testified that every milk crate has four gallons of milk in it. (Tr. 168-169.) He testified further that in the trailer, there was a milk crate missing two gallons of milk. (Tr. 169.) Ross, Jr. testified neither he nor anyone else touched or went inside the trailer from the time Petitioner was injured to the time Ross, Jr. took those pictures. (Tr. 169, 181.) When asked why he took the pictures, Ross, Jr. testified "[b]ecause there's no reason for milk to be on the ground in any trailer." (Tr. 170.) Ross, Jr. testified drivers are not supposed to enter a trailer in the warehouse at the end of the day. (Tr. 170.) He testified once a driver turned in his paperwork, the driver was done for the day, with no further responsibilities. (Tr. 171.) Ross, Jr. testified that only he or Ross, Sr. could authorize a driver to go into a trailer in the dock area after the driver returned. (Tr. 171.) Ross, Jr. testified did not give Petitioner permission to enter the trailer on June 7, 2018. (Tr. 171.) Ross, Jr. testified the distance from the lip of the trailer to the ground was approximately five feet. (Tr. 172.) In reference to RX12, Ross, Jr. testified that the video showed the proper method for entering and exiting a trailer. (Tr. 172.) Ross, Jr. further testified it is prohibited for drivers to jump from a trailer due to safety reasons. (Tr. 172.)

On cross examination, Ross, Jr. testified that he never climbed inside the trailer in the video (RX12). (Tr. 173.) Ross, Jr. testified that someone inside the trailer, in order to climb out, would have to grab the rail, turn around, and descend the same way that Ross, Jr. did in the video. (Tr. 173.) In reviewing the photos marked as RX14, Ross, Jr. testified that sometimes trailers are not completely filled with milk. (Tr. 175.) Ross, Jr. testified that RX14 showed the back and the side door of the trailer. (Tr. 175.) Timestamps on the photos verified the photos were taken at 4:34 p.m. on June 7, 2018. (Tr. 179.) Ross, Jr. testified that he did not know who put the milk on the ground of the trailer but it was not there when Petitioner brought the trailer back and Ross, Jr. inspected it. (Tr. 180.)

On redirect examination, Ross, Jr. testified that once Petitioner parked the trailer in the dock and Petitioner walked into the office, only Ross, Jr. had access to the trailer. (Tr. 181-182.) Ross, Jr. testified he did not move any milk product after taking the pictures. (Tr. 182.)

Testimony of Maribel Rubio

Maribel Rubio ("Rubio") testified that she is currently employed by Respondent and she worked for Respondent on June 7, 2018 as the operations manager. (Tr. 184-185.) She testified her job duties included overseeing the office and a couple of the drivers on everyday operations

and workers' compensation claims. (Tr. 185.) She testified she is familiar with Respondent's workers' compensation policies. (Tr. 185.) Rubio testified that when an employee is injured, she immediately contacts the insurance company to let it know about the injury, and then she fills out the Form 45 first injury report. (Tr. 186.)

Rubio testified she heard from Ross, Sr. that Petitioner had given his two-weeks-notice, and June 7, 2018 was going to be his final day of employment with Respondent. (Tr. 188.) Rubio testified she became aware of Petitioner's injury on June 8, 2018. (Tr. 188.) She testified that at that point, she called the insurance company. (Tr. 188.) In reviewing the document that is marked as Respondent's Exhibit Nine (RX9), Rubio testified that she completed the form (Form 45) on June 8, 2018. (Tr. 189-190.) She testified that she wrote "not a Workmen's Comp case" on the form because she "called up the insurance company and they advised [her] to fill that out, to the best of [her] knowledge, and to make sure that [she] put up on top there 'not a Workmen's Comp case' because it had happened on the 7th when [Petitioner] had terminated employment." (Tr. 190.) When she completed the form, she had not spoken to any of the drivers or anyone else. (Tr. 190-191.)

Rubio testified payroll usually arrives on Thursday mornings and normally employees were paid on Fridays. (Tr. 192.) Rubio testified she believed Petitioner was given his paycheck on June 7, 2018 so that he would not have to return to pick up his check on Friday. (Tr. 192.) Rubio testified that in her opinion, Petitioner's employment terminated when he was given his check. (Tr. 192.)

On cross examination, Rubio testified that when completing RX9, she spoke to an insurance agent and not an adjuster. (Tr. 195.) She did not speak to Ross, Sr., Ross, Jr., or Callahan at the time that she completed the form. (Tr. 195.) Rubio testified she found out about the incident from "the girls" at the office and she probably found out that Petitioner had been in the hospital from one of the other managers. (Tr. 195.) When asked about the part of the Form 45 (RX9) that references stealing two gallons of milk and falling while trying to get down from the trailer, Rubio stated that she received this information from a different manager, probably Norm Frey, Sr. or Karen Purpura. (Tr. 195-196.) When asked about the wording on the Form 45 that states: "He lost his footing getting down from trailer," Rubio testified, "[t]hat was an assumption on my part." (Tr. 196.)

Testimony of Juan Montoya (in Rebuttal)

In reviewing RX14, Petitioner testified that the photo on the second page shows that the milk crates on the right were full because "[y]ou could see the white." (Tr. 198.) Petitioner testified that he was not stealing two gallons of milk on June 7, 2018. (Tr. 198.) Petitioner testified that he was paid well when he worked for Respondent and he had no reason to steal two gallons of milk. (Tr. 204.) Petitioner testified that the photos could have been of any trailer and there was nothing in the photo that could identify the trailer as being the trailer that he brought in on June 7, 2018. (Tr. 204-205.)

Petitioner testified that he had never seen Ross, Jr. inspect a trailer after a driver arrived at Respondent's facility with a truck load. (Tr. 200.) Petitioner testified that the paperwork he

had for each truck load recorded the amount of product that he should have in each load and if anything was missing, it would be apparent when the paperwork was inspected the next day. (Tr. 201.) Petitioner testified that there would be no reason to inspect the inside of the trailers. (Tr. 201.)

Petitioner testified that he could not remember if he received a paycheck on June 7, 2018. (Tr. 201.) When asked if he told Frey that he had jumped and that he did a stupid thing, Petitioner testified: "I don't recall talking to him. I didn't know his name until now. I see him sitting here. I knew him facially. I know I spoke to him, and I recognized him." (Tr. 201.) When asked if he told Frey that he had jumped, Petitioner said no. (Tr. 201.) Petitioner testified that he had never jumped out of a trailer. (Tr. 202.) Petitioner testified that when he was leaving the trailer just before he fell, two gallons of milk were not on the floor of the trailer. (Tr. 202.)

Petitioner testified that on June 7, 2018, Ross, Jr. did not tell him to leave the tractor hooked to the trailer. (Tr. 206.) Petitioner testified that on June 7, 2018, after he turned in his paperwork from his last haul of the day, he still needed to do his "post-trip." (Tr. 207.) Petitioner testified that a post-trip is a DOT requirement for truck drivers to do at the end of the day. (Tr. 207.) Petitioner testified that a post-trip includes walking through the tractor-trailer and verifying that everything is in good condition. (Tr. 207.) Petitioner testified that he is required by DOT safety rules to inspect his truck load after he brings it in. (Tr. 203.)

On cross examination and redirect examination, Petitioner testified that if he was caught stealing, it would have jeopardized the job that he had planned to start the following week and would have jeopardized his chances at getting any other job as a driver. (Tr. 210.) On redirect examination, Petitioner testified that getting caught stealing would not have jeopardized his Class A commercial driver's license. (Tr. 211.)

Medical Records

Records from the Village of Bridgeview Fire Department indicate that on June 7, 2018, at approximately 4:08 p.m., an ambulance was dispatched to Respondent's facility. The ambulance arrived at Respondent's facility at approximately 4:12 p.m. The Emergency Medical Services ("EMS") note indicates that the EMS crew found Petitioner on the ground between two semi-trucks. The EMS note also states: "Bystanders on scene stated pt tried to jump out the side door of the truck approximately 3-4 feet high to the ground. Pt stated he landed and felt a crack in his leg." Petitioner was transported to Advocate Christ Medical Center. (Resp't's Ex. 10.)

Medical records from Advocate Christ Hospital Emergency Room dated June 7, 2018 include a history stating: "32 yo patient who came to the hospital after he tried to get off his truck and landed on his left leg (sic) which twisted and he heard a crack." (p. 40.) Petitioner underwent X-rays of the left leg (p. 130,) and was diagnosed with acute left tibia and fibula closed, displaced shaft fractures. (pp. 42-43.) The Admit History and Physical Note dated June 7, 2018, states: "32yo M w/ no pmhx who p[r]esents with leg pain. Pt was making sure everything was situated on his semi truck. When he decided to jump off. His right leg got stuck behind him, he landed on his left leg awkwardly and heard a crack. Then fell forward [sic]." (82, 91.) On June 8, 2018, Petitioner underwent a left intramedullary nailing of a tib-fib fracture. (p.

86.) On June 11, 2018, Petitioner was discharged from the hospital. (p. 40; Resp't's Ex. 11.)

On June 22, 2018, Petitioner sought treatment from Dr. Blair Rhode at Orland Park Orthopedics. Petitioner reported that he sustained a tibia and fibula fracture on June 7, 2018 "due to a fall at work." Petitioner also reported that "on 6/7/18 he had just fastened a safety bar and went to get off the truck when he became tangled and fell awkwardly onto the left leg." Petitioner underwent surgery to the left leg on June 8, 2018 and reported having continued knee and ankle discomfort secondary to the healing fracture. Dr. Rhode assessed that Petitioner had knee pain and closed fractures of the tibia and fibula. Dr. Rhode recommended that Petitioner wear a CAM walker, non-weight bearing, and placed Petitioner off work. (Pet'r's Ex. 2.)

Petitioner underwent physical therapy at ATI Physical Therapy on June 27, 2018 and attended physical therapy there until October 23, 2018. (Pet'r's Ex. 3.)

On November 19, 2018, Petitioner followed-up with Dr. Rhode and reported moderate knee symptoms. Dr. Rhode administered an injection into Petitioner's left knee and recommended that Petitioner follow-up again in two weeks to consider whether he was at maximum medical improvement. Dr. Rhode recommended that Petitioner advance to full duty work on a trial basis. (Pet'r's Ex. 2.)

On December 3, 2018, Petitioner returned to Dr. Rhode. Dr. Rhode released Petitioner to full duty work and opined that Petitioner had reached maximum medical improvement. (Pet'r's Ex. 2.)

CONCLUSIONS OF LAW

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

WITH RESPECT TO ISSUE (B), WAS THERE AN EMPLOYEE-EMPLOYER RELATIONSHIP, THE ARBITRATOR FINDS AS FOLLOWS:

I. Issue B – Was there an employee-employer relationship?

A threshold inquiry to be made in any claim arising under the Workers' Compensation Act is whether the claimant is an employee. *See Bauer v. Industrial Com.*, 51 Ill. 2d 169, 171, 282 N.E.2d 448, 450 (1972). There can be no hard and fast rule for making such a determination and the facts of each case are the only guides. *Id.* In Illinois, "[c]ompensation coverage is not automatically and instantaneously terminated by the firing or quitting of an employee . . . . The contract of employment is not fully terminated until the employee is paid, and accordingly an employee is in the course of employment while collecting his pay." *Gunthrop-Warren Printing Co. v. Industrial Com.*, 74 Ill. 2d 252, 257-58, 384 N.E.2d 1318, 1321 (1979) (*quoting* 1A A. Larson, Workmen's Compensation secs. 26.10, 26.30, at 5 -- 228, 5 -- 240 (1978).)

In this case, Petitioner testified that he could not recall if he received a paycheck at the end of the day on June 7, 2018, but he did not think that he did receive a paycheck that day.

Petitioner also testified that he was always paid for the previous week of work and his wife drove him to pick up his last paycheck from Respondent's facility on a subsequent date, no more than one month after the June 7, 2018 incident. Ross, Sr., Respondent's co-owner and president, testified that he instructed Callahan to give Petitioner a paycheck on June 7, 2018. However, Ross, Sr. also testified that if Petitioner received a check on June 7, 2018, it would have been for the previous week of work. Callahan testified that he gave Petitioner a paycheck on June 7, 2018 but did not testify as to whether the check was for the previous week of work or for the work performed during the week of June 7, 2018.

The Arbitrator finds that Petitioner's testimony was less than credible generally, and finds that the testimonies of Ross, Sr. and Callahan were credible. Specifically, the Arbitrator finds credible Ross, Sr. and Callahan's testimonies that Petitioner was given a paycheck on June 7, 2018. The Arbitrator finds significant Ross, Sr.'s testimony that on June 7, 2018, Petitioner was paid for the previous week of work. Thus, the Arbitrator finds that Petitioner likely received his final paycheck on a date after June 7, 2018. Accordingly, the Arbitrator finds that an employee-employer relationship existed between Petitioner and Respondent on June 7, 2018 at the time of Petitioner's injury and the employee-employer relationship did not terminate until Petitioner was given his final paycheck on an unknown date after June 7, 2018.

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

"Arising out of"

For an injury to "arise out of" employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665 (1989). The mere fact an incident occurred on the premises of the employer is not sufficient to fulfill the "arising out of" requirement. *Builders Square v. Industrial Comm'n*, 339 Ill. App. 3d 1006, 1010-11, 791 N.E.2d 1308, 274 Ill. Dec. 897 (3d Dist. 2003.) The initial step in considering the "arising out of" component of a worker's compensation claim is to determine the type of risk to which the claimant was exposed at the time of his injury. *Baldwin v. Illinois Worker's Compensation Comm'n*, 409 Ill. App. 3d 472, 478, 949 N.E.2d 1151, 351 Ill. Dec. 56 (4th Dist. 2011). "Risks to employees fall into three groups: (1) risks distinctly associated with the employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics." *Id.* "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Worker's Compensation Comm'n*, 407 Ill. App. 3d 1010, 1014, 944 N.E.2d 800, 348 Ill. Dec. 559 (1st Dist. 2011).

When an employee voluntarily exposes himself to an unnecessary personal danger solely for his own convenience, then the case law is clear such an injury does not "arise out of" employment. *See Hatfill v. Industrial Comm'n*, 202 Ill. App. 3d 547, 148 Ill. Dec. 67, 560 N.E.2d 369 (1990) ("holding that claimant's injury did not arise out of employment because

instead of using the walkways located 50 feet to his left and right, claimant took a shortcut by jumping across some water that had accumulated at the foot of the five-foot incline leading to the parking lot's upper level"); *see also Dodson v. Industrial Comm'n*, 308 Ill. App. 3d 572, 720 N.E.2d 275 (5th Dist. 1999) ("denying a claim for benefits where the claimant choice to deviate from the sidewalk and walk across a grassy slope to reach her car was personal in nature and designed to serve her own convenience and not the interests of her employer.")

In the case at bar, Petitioner's testimony regarding how he ended up on the ground injured on June 7, 2018 is not credible and is contradicted, not only by the credible testimony of Respondent's witnesses, but also contradicted by the medical records. Petitioner testified he was climbing down from the trailer when his foot either became caught or stuck on a pallet or a nail. Petitioner also testified that his dismount from the trailer was "kind of a jump off fell off" action. Petitioner unsuccessfully attempted to clarify his statements by testifying that he meant "tangled on a nail" and by stating "Yeah, pushed myself off" when asked if he had jumped.

The Arbitrator finds more credible than Petitioner's description, the paramedics' report from the date of accident stating: "bystanders on scene stated [Petitioner] tried to jump out the side door approximately 3-4 feet high to the ground." Frey credibly testified that Petitioner told Frey that Petitioner jumped from the truck, and Mr. Frey relayed this information to the paramedics. Also more credible is the Admit History and Physical Note dated June 7, 2018, which states: "Pt was making sure everything was situated on his semi truck. When he decided to jump off." The Arbitrator finds significant the evidence demonstrating the proper way to climb out of a trailer, and finds Petitioner did not exit the trailer in the proscribed manner. Petitioner admitted he knew he was supposed to use the steps when climbing down from the trailer and he knew this was company policy.

Thus, the Arbitrator finds Petitioner's June 7, 2018 injury did not arise out of Petitioner's employment with Respondent. In so finding, the Arbitrator finds the evidence establishes Petitioner was injured when he voluntarily jumped out of the trailer. The Arbitrator finds that jumping out of the trailer was a neutral risk having no particular employment or personal characteristic. Additionally, Petitioner was not exposed to this risk at a greater degree than the general public. The risk resulting in the Petitioner's injury was of jumping out of the trailer, an act which the evidence and testimony provided shows was not reasonably expected to be performed in connection with the Petitioner's assigned duties as a truck driver for Respondent.

"In the course of"

Based on the Arbitrator's finding that Petitioner's June 7, 2018 injury did not arise out of Petitioner's employment with Respondent, the Arbitrator finds that the issue of whether the June 7, 2018 incident occurred in the course of Petitioner's employment with Respondent is moot.

III. 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 finding that Petitioner's June 7, 2018 injury did not arise out of Petitioner's employment with Respondent, the Arbitrator finds that the issues of whether the medical services were reasonable and necessary and payment for medical services are moot.

IV. Issue K – What temporary benefits are in dispute (TTD)?

Based on the Arbitrator's finding that Petitioner's June 7, 2018 injury did not arise out of Petitioner's employment with Respondent, the Arbitrator finds that the issue of entitlement to temporary total disability benefits is moot.

V. Issue L – What is the nature and extent of the injury?

Based on the Arbitrator's finding that Petitioner's June 7, 2018 injury did not arise out of Petitioner's employment with Respondent, the Arbitrator finds that the issue of the nature and extent of petitioner's injuries is moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC010108
Case Name	STALNAKER,JUDY N v. CITY OF CHGO OFF OF EMERGENCY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0214
Number of Pages of Decision	34
Decision Issued By	Barbara Flores, Commisioner

Petitioner Attorney	Edward Spitz
Respondent Attorney	Aukse Grigaliunas

DATE FILED: 4/29/2021

Dissent by Deborah Simpson

/s/*Barbara Flores, Commissioner*

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDY STALNAKER,

Petitioner,

vs. NO: 08 WC 10108

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, 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.

I. FINDINGS OF FACT

The Commission elaborates on the Decision of the Arbitrator with respect to the issues of medical expenses and the nature and extent of Petitioner's injury. In so doing, the Commission notes that Petitioner had prior bilateral total knee replacement surgeries in 2000 after which she worked for Respondent until she sustained the undisputed accident at work giving rise to the issues on review. On January 31, 2008, Petitioner was working for Respondent as a traffic guard at the intersection of Clark and Jackson. While directing traffic, she was struck by a taxi and knocked to the street. Petitioner testified that she felt pain mostly in her right leg, and was taken by ambulance to Northwestern Hospital.

A. Medical Treatment

The emergency room records reflect that Petitioner presented with right knee pain after being hit by a turning vehicle while working as a traffic guard. She was unable to ambulate. The bone health consultation note states that, "[d]espite her age, due to the origin of the fracture, it cannot be attributed to fragility or osteoporosis." X-rays showed severely comminuted

fractures of the distal femur at the level of the existing total right knee prosthesis, which appeared intact. A CT showed a non-restrained cemented right knee prosthesis, severe degenerative joint disease of the patellofemoral knee joint, severely commuted, angulated, displaced and foreshortened fracture of the right femur, not affecting the prosthesis, incomplete non-displaced fracture of the medial cortex of the right proximal tibia, small hematoma in the right intermediate vastus muscle, and remote Pelligrini-Steida injury of femoral origin of the medial collateral ligament.

The following day, on February 1, 2008, Dr. Cordes performed right distal femur open reduction internal fixation (ORIF) surgery with bone-grafting for comminuted supracondylar periprosthetic femur fracture.

On February 9, 2008, Petitioner was discharged with a diagnosis of periprosthetic distal femur fracture, instructed to follow up with Dr. Cordes in 10-14 days, and transferred to Rehabilitation Institute of Chicago (RIC). On March 10, 2008 she was transferred to a sub-acute nursing facility, but had difficulties with DVT and Coumadin failure. She was transferred back to RIC on April 22, 2008 after she was able to bear weight and began formal physical therapy there on April 30, 2008. Petitioner also underwent treatment for post-operatively developed DVT through April of 2008. Petitioner was discharged on April 29, 2008 when it was determined that she was 50% weightbearing and transported home by ambulance.

Petitioner continued to treat with Dr. Cordes through 2008 and continued physical therapy. Petitioner underwent a functional capacity evaluation (FCE) on January 7, 2009 which placed her at "light-duty sedentary work." It was noted that Petitioner could walk on an occasional basis, continually, for approximately 18 minutes and without a cane for less than 10 minutes. The evaluating therapist determined that Petitioner gave appropriate effort and the results were considered to be a valid assessment of her functional capabilities. She was placed at the light physical demand level (i.e., able to exert 20 pounds of force occasionally and 10 pounds frequently). Petitioner testified that Respondent did not have any such jobs available.

On January 20, 2009, Petitioner returned to Dr. Cordes at which time he advised that she was likely at MMI, but could not return to her prior job. He believed she could work in a seated position with limited standing/walking and he would see her again in six months.

As of July 14, 2009, Dr. Cordes noted that Petitioner was able to ambulate a limited distance around the house without a cane. Her prosthetic knee seemed to be in good alignment and there was no evidence of hardware failure. However, he noted that there was no light work available and Petitioner was unable to rejoin the workforce. Dr. Cordes indicated that Petitioner was most likely at maximum medical improvement (MMI) and scheduled a follow up visit in six months.

On January 12, 2010, Petitioner reported that she ambulated outside with the four-pronged cane and ambulated without a cane in her home. Dr. Cordes noted that Petitioner's

regular orthopedic surgeon was concerned about possible nonunion, but Dr. Cordes did not believe there was a true nonunion. He noted that no light duty was available and placed Petitioner at MMI.

Petitioner returned to Dr. Cordes on June 24, 2010 with recent onset of swelling around the knee. He noted that Petitioner was at increased risk for premature loosening of the components on the right relative to the left knee, but no intervention was indicated at that time. Dr. Cordes released Petitioner from treatment to return yearly or as needed.

B. Return to Light Duty Work

Petitioner testified that sedentary jobs were still not available. Respondent summoned Petitioner to a meeting on June 24, 2010. Petitioner testified that she provided Respondent's human resource department with her work history and was informed that they did not have any jobs for her. She was also told that he had to fill out 10 job applications a week.

The record reflects that Petitioner was provided with blank "City of Chicago Injury on Duty Job Search Log" sheets to complete which states to "deliver it in person each week to the address listed below[]" to avoid suspension or termination of her disability payments. Petitioner identified her job search logs, which were offered into evidence. The logs include approximately 82 pages with some undated pages. Approximately 490 dated entries begin on July 15, 2010 through April 25, 2011. Petitioner testified that the job applications she submitted were for jobs with potential employers other than Respondent.

Petitioner testified that she stopped participating in the vocational program around April 25, 2011 because Dr. Cordes indicated that she was no longer at MMI and her leg was getting shorter. He advised her to see a spine surgeon for that condition.

C. Continued Medical Treatment

The medical records reflect that on February 14, 2012 Petitioner presented to Dr. DeWald at Rush for evaluation of degenerative kyphoscoliosis. Petitioner presented with an obvious short leg gait and Dr. DeWald noted severe lumbar degenerative disc disease. He attributed most of her conditions to the shortened leg and difficulty ambulating which related back to her work accident and resulting ORIF surgery. He recommended she see a rehabilitation specialist. Petitioner testified that she has not had recommended surgery.

On March 21, 2012, Petitioner returned to Dr. Cordes who ordered a CT and informed her that there was a nonunion in her right knee. A CT of the right knee on that date revealed chronic nonunion of the distal femoral metaphysis. The study reflects increased hardware failure and possible chronic osteomyelitis with cutaneous sinus tract as the cause of the nonunion. He recommended additional surgery.

Petitioner testified that she wanted to get a second opinion and saw Dr. Virkus. The medical records reflect that she presented to him on July 10, 2012 for a new patient evaluation. She reported that her pain was increasing over the past number of months to the point where she now frequently used a scooter for longer distances. Petitioner was 5'4" and 278 lbs. and noted to be morbidly obese. X-rays showed a clear nonunion. Dr. Virkus discussed various surgical options with Petitioner including a revision of the ORIF surgery, resection of the distal femur nonunion, and a revision of the knee with a hinged prosthesis. He recommended the hinged knee option and Petitioner accepted the recommendation. Dr. Virkus noted that they would await approval.

D. Respondent's First Section 12 Examination – Dr. Garapati

Petitioner submitted to a Section 12 examination with Dr. Garapati at Respondent's request on September 24, 2012. Dr. Garapati issued a report of the same date. He noted Petitioner's report that, despite prior bilateral total knee replacements in 2000, she had no pain in her knees prior to her accident on January 31, 2008.

Petitioner reported that she had surgery and was non-weightbearing for an extended period. She complained of significant pain in her right leg. Petitioner was able to drive and get into/out of her car, could perform some household chores, but could not walk any significant distance or perform ADLs. She used a walker for ambulating longer distances. Her right leg was one-to-two centimeters shorter than the left. She still had good range of motion in the knee. She was neurovascularly intact. Dr. Garapati noted that Petitioner could walk but with a significant antalgic gait and has difficulty walking without any assistance and rather holds onto the cart and table in her room. Petitioner was also able to walk with a walker, but with significant difficulty and unable to walk a significant distance.

Dr. Garapati took x-rays in which the right arthroplasty appeared to be intact, but there was significant varus angulation of the distal femur fracture and callus formation, and no good evidence of bridging callus formation. Dr. Garapati also noted that some of the screws appeared to be broken.

Dr. Garapati diagnosed Petitioner with a comminuted right distal periprosthetic fracture from the accident and determined that she currently had a nonunion with angulation, bone loss, and shortening of the right distal femur. He opined that Petitioner's condition was directly caused by the work accident.

Dr. Garapati noted that Petitioner's condition was "very complicated" given her situation and limited options. He did not believe doing nothing was a viable option and recommended further surgical intervention consisting of a nonunion repair with iliac crest bone grafting and revision ORIF, or a distal femoral replacement with a hinged knee type prosthesis. Dr. Garapati recommended the latter surgery. He also noted that this was very specialized surgery and identified some local surgeons who could perform it. Dr. Garapati further opined that, without

intervention, Petitioner's prognosis was very poor, and she would not have significant improvement.

Dr. Garapati found that Petitioner was not at maximum medical improvement and he recommended further surgical intervention. He opined that Petitioner would only be suitable for a sedentary job with no significant walking and no carrying.

E. Continued Medical Treatment

Petitioner testified that Dr. Virkus left town and referred her to Dr. Gitelis. The medical records reflect that Petitioner presented to Dr. Gitelis on January 21, 2013. He noted that x-rays showed more varus deformity in the knee and more hardware deflection. The surgery he envisioned would be very complex due to her obesity.

In a letter dated March 1, 2013, Dr. Gitelis informed Respondent's nurse case manager from Coventry that he would be performing a complex limb preservation and reconstruction operation on Petitioner who was largely non-ambulatory. Dr. Gitelis noted that Petitioner had nonunion of her femur and that she was referred by a trauma reconstruction surgeon who indicated there was very little that he could offer her. He further noted that Petitioner would need comprehensive medical evaluation to determine whether she could tolerate such as significant operation.

On March 18, 2013, Dr. Gitelis was unable to aspirate Petitioner's knee due to her obesity, which was required to ensure that her nonunion was not caused by infection pre-operatively. He ordered an ultra-sound guided aspiration, which was to be performed on March 21, 2013.

Petitioner testified that the surgery was scheduled, but Dr. Gitelis called her and cancelled it. The record reflects a note dated April 17, 2013 from Dr. Gitelis that he was concerned about performing the procedure given Petitioner's condition and comorbidities, which could result in amputation, a risk he was unwilling to accept. A letter to Respondent's nurse case manager dated April 18, 2013 reiterated his concerns, and recommendation that Petitioner obtain a second opinion and probably surgical reconstruction with Dr. Sim at the Mayo Clinic. Petitioner testified that Respondent did not authorize the surgery at Mayo, but allowed her to choose another doctor; she saw Dr. Peabody at Northwestern.

The medical records reflect that on July 29, 2013, Petitioner returned to Northwestern and saw Dr. Peabody and his resident. She reported ongoing right knee pain affecting her daily living for years adversely affecting her quality of life, especially as of late. Petitioner ambulated for a few steps at home with the aid of a walker, but predominantly used a scooter. She had to take narcotic medication for the pain. Imaging showed nonunion of the right periprosthetic distal femur fracture, with multiple screw failures, and significant shortening. Dr. Peabody stated that treatment options included conservative treatment with pain medication, amputation, knee

fusion, or hinged knee prosthesis. Petitioner indicated that she did not wish to have an amputation or knee fusion, but could not continue to live in her current state, and elected for revision surgery.

On August 26, 2013, Petitioner returned to Dr. Peabody to discuss management of her knee pain. She was taking Norco, using compression stockings, and was not attempting any motion of the knee. Dr. Peabody believed that resecting the femur and reconstructing in one stage was a mistake because of the increased danger of infection. He recommended a two-stage surgery including a resection arthroplasty, removal of hardware, rod and cement spacer with cultures and ID consultation followed by six weeks in a skilled nursing facility and then a replant of the distal femur and hinged knee, if possible. Petitioner was considering non-operative treatment and was seeing someone at RIC.

On October 28, 2013, Dr. Peabody noted that the knee pain had been stable, and Petitioner was somewhat content with the current status of her complicated knee pathology. He maintained his recommendation for a two-stage surgical intervention, which Petitioner understood would not significantly improve function, but would stabilize the femur and reduce the risk of infection. Petitioner was still considering conservative treatment.

On January 20, 2014, Dr. Peabody re-aspirated Petitioner's knee and maintained his recommendation for staged surgical intervention. As of April 9, 2014, Dr. Peabody noted that x-rays showed progressive shortening of the right leg, displacement of the distal femur with loose hardware, and a screw projecting laterally. Petitioner was under cardiac evaluation having spent two months hospitalized for afib as well as renal and other issues. Petitioner's nonunion site appeared to be infected. Dr. Peabody continued to recommend the major two-stage surgery noting that infection was problematic. He noted that the limb would have to remain shorter and amputation above the knee was a possibility.

Dr. Peabody continued to treat Petitioner conservatively. He aspirated her knee on June 11, 2014. As of March 2, 2015, Dr. Peabody noted she was doing worse with more difficulty getting around. Imaging showed nonunion throughout the knee and possible infection. Dr. Peabody believed that amputation might be her best option, though it would significantly change her living situation, and that she might not be a candidate for re-implantation such that, alternatively, a fusion might be best. He would order another aspiration.

On April 6, 2015, Petitioner reported that her pain was increasing but she was able to walk limited distances with a walker. Dr. Peabody informed her that they could remove the hardware but that included risks of infection and he was concerned about her history of DVT. In addition, there was no guarantee that her function would be any better and her leg may still have to be amputated. Dr. Peabody noted that no further cardiac workup was recommended by preop, and he recommended the two-staged surgery noting that the second stage surgery could be a replant, if possible, or a fusion.

On April 16, 2015, Petitioner underwent a resection for failed hardware, right lateral femoral plate and multiple broken screws (two of which required a separate incision in addition to a lateral incision, one of which required drilling into the bone proximally in order to remove the broken fragment left in the bone), removal of distal femur including the distal femoral component, but resecting essentially to the fracture site, removal of the tibial prosthesis, removal of cement of the proximal tibia, placement of an intermedullary nail between the tibia and femur, and placement of an antibiotic cement spacer over the rod. Dr. Peabody's postoperative diagnosis was of nonunion right distal femur, periprosthetic femur fracture, infected total knee arthroplasty (right).

Petitioner followed up with Dr. Peabody and at Northwestern for post-operative care while at RIC and thereafter. Petitioner testified that she was fitted with a power wheelchair, which she still used. The medical records reflect that on May 4, 2015, Dr. Peabody noted that Petitioner's wounds were healing but she had severe lymphedema on both legs. She had to be a splint for six weeks. As of June 22, 2015, Petitioner remained at RIC and was compliant with a knee brace locked in extension. Dr. Peabody noted that Petitioner "was educated on the need to keep brace on throughout her life Ok to take off brace to shower[.]" On August 24, 2015, Dr. Peabody advised she might need additional surgery to remove hardware. He also prescribed Norco, continued her home exercise program, and provided a new brace.

F. Transportation

While in post-operative treatment, Petitioner received some information from the Regional Transportation Authority (RTA) in response to her application for ADA Paratransit services. On August 28, 2015, RTA informed Petitioner that she was eligible for "some" ADA paratransit services. RTA noted that Petitioner's wheelchair was not a standard size, "which may cause difficulty in using a bus lift or maneuvering to the securement area. In addition, due to [her] use of a wheelchair, [she was] unable to maneuver on curbs, uneven or unpaved surfaces, or when snow or ice is on the ground." Notwithstanding, RTA determined that Petitioner was able to perform the necessary tasks for independent travel on fixed routes under "some" conditions. RTA further determined that Petitioner demonstrated the ability to travel four blocks in her motorized wheelchair, cross streets in a timely fashion, negotiate curbs and terrain, and use accessible fixed route bus and train service. Petitioner was deemed eligible to use ADA paratransit where there were no curb cuts, where sidewalks were in good condition, when there was no snow or ice on the ground, and only during the winter months of November 15 to March 15. Petitioner was informed that her eligibility for these services would expire on February 28, 2019.

On February 16, 2016, Petitioner received a letter from Pace Paratransit Operations in response to her complaint dated January 21, 2016. In the letter, Pace noted that a road supervisor came to her home to measure her wheelchair because she was being sent vehicles that could not accommodate it or her extended leg. Ms. Gettes, Project Manager, Quality Assurance, advised Petitioner that "[d]ue to your leg being extended beyond the normal spacing of a wheelchair,

there may be instances where your wheelchair cannot be safely secured. Wheelchairs must be secured forward facing; If the rider cannot be secured safely then they will not be able to be transported."

Petitioner testified that she purchased a van that would accommodate her wheelchair because she was otherwise unable to go anywhere. She also testified without rebuttal that she purchased the van from MobilityWorks, a company which sells automobiles and other accessible equipment for the disabled. The record reflects a purchase order from MobilityWorks totaling $37,662 due on delivery for a used 2015 Dodge Grand Caravan, itemized as including a $22,000 chassis price and a $17,900 conversion price. The purchase order further included a $2,500 trade-in credit for her car. Petitioner testified that she was making monthly payments for the van.

Petitioner also testified that she had a lift installed in her home, which later had to be repaired. Respondent paid for the installation but not the repairs, which Petitioner paid. Referring to Petitioner's Exhibits 13 and 16, Petitioner testified regarding the bills for the maintenance of the lift incurred by Access and Extended Home Living.

G. Continued Medical Treatment

In the interim, Petitioner returned to Dr. Peabody for continued follow up care. As of November 30, 2015 and June 28, 2016, Petitioner was unwilling to have a fusion or attempted reconstruction surgery, and Dr. Peabody remained concerned about her post-operative complications. He recommended that she was best left as is, in a long brace.

On July 15, 2016, Dr. Peabody issued a letter indicating that Petitioner was being treated for multiple medical conditions. She had a right-knee fusion for an infection following treatment of her periprosthetic femur fracture, wore a locked brace at all times, got about in a motorized chair, and required narcotic medication for chronic pain. Dr. Peabody indicated that Petitioner "requires assistance for mobility and for activities of daily living including bathing because of impaired mobility, morbid obesity, advanced age and sarcopenia." He further stated that her condition was permanent.

Petitioner continued to follow up with Dr. Peabody through 2017 and 2018. A hospital bed was ordered for Petitioner's home on May 22, 2017. As of February 5, 2018, Dr. Peabody authored another letter reiterating Petitioner's medical needs and condition as permanent. On November 5, 2018, Dr. Peabody noted that Petitioner got around in a motorized wheelchair and could stand and walk for very limited distances with assistance. X-rays showed no change in Petitioner's condition. He noted that he had no additional suggestions at that time, her pain medication was being managed by her primary care physician, and he would see her in six months.

In October of 2017, Petitioner paid for installation of entry doors from WindowWorks and testified that she did so to be able to go in and out of her home with the wheelchair.

H. Respondent's Second Section 12 Examination & Deposition Testimony – Dr. Koehler

On cross-examination, Petitioner testified that she was truthful with Dr. Koehler about her condition. She also agreed that Dr. Peabody no longer was prescribing her medication. Her current prescriptions come from her primary care physician. She filled out all the forms Respondent asked her concerning return to work. She can walk short distances out of her wheelchair, with assistance.

The record reflects that Petitioner submitted to a second Section 12 examination at Respondent's request with Dr. Koehler on February 28, 2018 and he issued his report on March 8, 2018. Dr. Koehler noted his review of records from Little Company of Mary Hospital, Northwestern Hospital, RIC, Dr. Cordes, Dr. Gitelis, Ability Lab, Dr. Zavala, and University of Chicago Medicine.

Regarding her medications, Dr. Koehler notes that she took: (1) Low dose aspirin; (2) Metoprolol 300 mg daily; (3) Propafenone extended release capsules, one twice a day; (4) Allopurinol 100 mg once a day; (5) Furosemide 20 mg three times a day; (6) Colchicine one Monday, Wednesday and Friday; (7) Sertraline one daily; (8) Montelukast 10 mg every evening; (9) Pantoprazole 40 mg one daily; and (10) Sodium bicarb 250 mg two tablets twice a day.

Regarding her activities of daily living, Dr. Koehler noted that Petitioner was bound in a high-tech, motorized wheelchair that could assist her getting in and out of it. She can traverse up ramps with her wheelchair. Petitioner's daughter and her husband live with Petitioner and provide a lot of the caretaking she needs, but she also has home health care three times per week by a caretaker who assists her in traversing the shower and removing and reapplying her brace for bathing. Petitioner needs assistance getting in and out of her brace and in getting in and out of her shower chair. Petitioner's daughter does the cooking. The caretaker does the laundry. Petitioner does some shopping with her daughter, and has a handicap van with a ramp that she is able to drive up and down, which helps her get to where she is going for shopping if necessary.

Dr. Koehler noted that Petitioner has a walker, but mostly is in the wheelchair. Also, her right lower leg is fixed and she experiences pain there, which "is problematic for her obviously with ambulation." Dr. Koehler noted that Petitioner had not returned to work since her accident and reported that this is due to the multiplicity of her complicated medical problems.

On physical examination, Dr. Koehler noted extensive swelling edema, pain to palpation of the lower right leg (which Dr. Peabody opines is probably related to the loosening he has noted of the distal component of the rod in her leg), and a fused right knee with no motion. Her strength in the lower extremities is 3/5. Dr. Koehler was able to have Petitioner stand, but she is unsteady in the standing position. Petitioner was able to walk with assistance. "However, she

has a fused right leg which makes it difficult to move and she is unsteady throughout. She would require a walker for any brief ambulation."

Dr. Koehler diagnosed Petitioner with: (1) Fused right knee, secondary to nonunion femur fracture with osteomyelitis; (2) Extreme obesity; (3) Obstructive sleep apnea; (4) Atrial fibrillation satisfactorily treated; (5) Chronic renal failure; (6) Asthma; (7) Gastroesophageal reflux disease; (8) Hypertension; (9) Bleeding complications secondary to anticoagulation, resolved; (10) Status post right ventricular laceration during cardiac procedure; (11) Deep venous thrombosis with IVC filter; (12) Bilateral total knee arthroplasties; and (13) Mild congestive heart failure on Lasix.

Ultimately, Dr. Koehler opined with a reasonable degree of medical and surgical certainty, as a board-certified occupational medicine specialist, as follows:

> "…[I]t is my opinion that the current diagnoses which relate to her accident dated January 31, 2008 are: 1) Fused right knee secondary to nonunion femur fracture with osteomyelitis. The basis of my answer is that Ms. Stalnaker was struck by a cab which was struck by a different car and the cab was shoved into her, causing the femur fracture. The femur fracture then went on to surgery which, unfortunately, had an infection deep within, which caused a nonunion of the bones, i.e., the bones did not fuse and did not heal properly, and she later had to go on to a Stage 1 fusion procedure; however, they were unable to go on to Stage 2 due to postoperative complications of renal failure, and at this time there is no surgeon willing to proceed with the second procedure to place a hinge in her knee. Therefore, she is now left with a fused knee in extension. She has a multiplicity of other medical diagnoses which do not relate to the fracture, i.e., the fracture did not cause any of those other medical conditions, nor did her subsequent nonunion and osteomyelitis relate to those conditions. She also had some complications of her medical treatments and procedures such as hammer joint anticoagulation and perforated right ventricle during the atrial appendage surgical procedure."

Dr. Koehler opined that Petitioner had reached maximum medical improvement with regard to her right knee noting "There are no prospects for improvement, as she is not a surgical candidate to have any further procedures on the knee, which would have to be significant and substantial, in that placing a hinge in the knee would require the removal of the rod and additional procedures on the bone, all of which would have risk of infection and her own risk of having medical conditions which are likely to be adversely affected by the surgical anesthesia and time under anesthesia she had previously. She had reached MMI with respect to her right knee when they fused the right knee in April 2015. In my opinion, no further treatment is indicated or safe for her to engage in."

Dr. Koehler was also asked to opine whether Petitioner would be able to return to work in any capacity with regard to her right leg or any other condition that might or could be related to the original injury. He opined as follows:

> "… Ms. Stalnaker can return to employment in my opinion. In particular, Ms. Stalnaker is very sharp mentally. She is able to answer questions briskly, quickly and appropriately. She was engaging and had an excellent attitude about her condition. She is motivated to do the best in her situation. She will be wheel-chair bound due to her medical conditions, which keep her wheelchair bound. It is my opinion that the primary reason for her being wheelchair bound is her extreme obesity rather than the knee fusion. The knee fusion would affect her ambulatory ability. However, if she was 150 pounds lighter, she would be able to ambulate rather efficiently. I say this because her hips are intact, her ankles and feet are intact, and there would be no reason she could not ambulate if she was 150 pounds lighter. Because of her mental sharpness, she would be able to work at a call center, answering the phones, such as logistics, 911/EMS or telecommunication call centers or utilities call centers or other similar sedentary work. Her wheelchair is very effective in its ability to adjust her and help her be properly positioned. She has had no problems with skin breakdown or ulceration. She has good sensory function and, therefore, she would be able to operate her wheelchair into a workplace to be seated at a work station and use a headset to speak and manage phone conversations and the like. The medical factual basis for this statement is as noted above. Her mental faculty is 100% intact. She is a fully capable individual from a mental standpoint and her wheelchair would enable her to traverse into any workplace setting with ease."

On October 26, 2018, Dr. Koehler, who is board-certified in occupational and emergency medicine, testified by deposition regarding the examination. About three-quarters of his practice involved treating patients, and one-quarter involved medical/legal issues. He reviewed Petitioner's records and examined her. Petitioner reported that she had right leg pain "and a fixed leg problematic for ambulation." She had a walker, but used a wheelchair most of the time.

Dr. Koehler recounted the specific details identified in his report about Petitioner's condition, her wheelchair, ability to ambulate with a walker short distances, and his diagnoses. He also testified about the opinions that he rendered in his report clarifying that the following conditions were related to Petitioner's accident at work: fused right knee, secondary to nonunion femur fracture with osteomyelitis; bleeding complications secondary to anticoagulation, resolved; and bilateral total knee arthroplasties. Dr. Koehler maintained his opinion that Petitioner had reached MMI as of April 2015.

Dr. Koehler also testified that Petitioner could not return to her regular job as a traffic control aide for Respondent, but she could return to other work. He explained that he believed that Petitioner could ambulate if she were 150 pounds lighter and her "mental facilities were

100% intact." He thought she would work in a call center and be able to position herself correctly with her high-tech wheelchair. He clarified that he believed Petitioner could work even if she did not lose 150 pounds.

On cross-examination, Dr. Koehler explained that the quarter of his practice, not involving treating patients, included consulting as well as IMEs. Petitioner's wheelchair was 3.5' wide and 4.5' long. When she appeared for his examination, Dr. Koehler understood that a van delivered her. He was unsure if it was a Pace van. Nobody was in the examination with her, but he could not recall if anyone came into his office with Petitioner.

Petitioner told him that she stopped treating with Dr. Cordes because he did not listen to her complaints about ongoing pain. She went to Dr. Virkus on referral from a friend. He then left the practice and referred her to Dr. Gitelis. He scheduled her for surgery but then referred her to Mayo Clinic. Dr. Koehler did not believe he saw any IME report from Dr. Garapati, unless he commented on it in his report.

Dr. Koehler testified that Petitioner never had the surgery to implant the hinged prosthetic because of medical complications unrelated to her accident. The knee was continuously braced and was fused with no motion, but it was "ever so slightly flexed" and not entirely straight.

Dr. Koehler agreed that the condition of Petitioner's leg was permanent, but he did not know that she was taking two 10 mg Norco pills at least three times per day. He testified that if she was taking that much, it was "a lot," but if she was in an office setting doing sedentary work her work performance might be an issue. However, he did not find Petitioner to be attenuated by narcotic medication when he saw her.

Dr. Koehler surmised that Petitioner would need a handicapped van to accommodate her oversized wheelchair to get to a job such as he suggested in his report. He agreed Petitioner was "incapable of being out of the wheelchair for any length of time." Dr. Koehler further agreed that a prospective employer would have to make certain accommodations for her primarily at the work station including a desk that was the right height, and accessibility to a keyboard and phone. He also testified that the facility would necessarily be ADA compliant. He did not recommend that she ambulate with a walker at work, even an ADA compliant institution, noting "I don't see any reason to do it. I mean, she's not going to be able to go to the bathroom with a walker because she can't go far enough."

On redirect examination, Dr. Koehler testified that the dosage of Norco that Petitioner's lawyer stated she was taking (two 10 mg pills daily) was excessive, not recommended to be taken on a long-term chronic basis, though he did not know the threshold off the top of his head, and it would affect her ability to drive. He did not see any medications on her list he thought was unreasonable, and his examination did not persuade him that she needed any other medication.

On further cross-examination, it was clarified that Dr. Koehler understood that Petitioner was taking Norco at the time of the deposition, not at the time of his examination. Being at MMI did not necessarily mean that a patient no longer needed to take medication.

I. Vocational Rehabilitation

1. Respondent's Labor Market Survey – Ms. Bethell (MedVoc)

On June 15, 2018, Jacqueline Bethell of MedVoc Rehabilitation issued a labor market survey at Respondent's request. Subsequently, Ms. Bethell was called as a witness by Respondent and gave testimony at an evidence deposition.

Ms. Bethell testified that she was a certified rehabilitation counselor since 2012. She confirmed that Respondent asked her to prepare a labor market survey regarding Petitioner, whom she had not met, based on Dr. Koehler's report.

In preparing her survey, Ms. Bethell talked to prospective employers to determine whether they were able to hire people with Petitioner's work history and be able to accommodate their impairments. Ms. Bethell specifically inquired whether the prospective employers could accommodate a large wheelchair, which Petitioner used. She called 24 such prospective employers, two would not consider a candidate like Petitioner, seven chose not to participate, and 15 indicated they would consider such a candidate.

With regard to potential wages, Ms. Bethell determined that the mean entry level compensation was $10.98 an hour. Since then, the minimum wage in Chicago was increased to $12 an hour, so the compensation for the jobs identified in Chicago would increase to at least that rate. She noted that any company with more than 20 employees had to be ADA compliant and found a stable labor market in areas such as concierge, greeter, and call center.

On cross-examination, Ms. Bethell testified that MedVoc did not provide vocational services to Petitioner. She also acknowledged that she was asked to provide a forensic assessment of Petitioner's employability by Respondent based solely on the report of Dr. Koehler.

Ms. Bethell also testified that Lauren Egle worked with her on the survey and "[Ms. Egle] called a lot of the employers." Ms. Bethell explained that she performs a "spot check" when she receives the labor market survey to double-check that they are getting the correct information. When asked about the specific list of questions asked of prospective employers that is filled out on a sheet in their file, the following exchange took place on cross-examination:

"Q But that's all you do is spot check, correct?
A Yes.

Q And in your file for each employer you call, you fill out a sheet that has a list of questions?
A Uh-huh.
Q Is that correct?
A Yes.
Q Can you read those questions into the record, please?
A Yes. Typically -- well, okay, No. 1, would you consider hiring an individual who has a lengthy work history as a traffic aide, can you accommodate sedentary work, can you accommodate an individual who is wheelchair bound, what is the anticipated entry level wage, are you currently hiring or anticipate hiring within 90 days, best method to apply and essential job tasks."

Ms. Bethell testified that she created the list of questions to be asked of the prospective employers, but acknowledged that she did not spot check all of the contacts made. Ms. Bethell agreed that to perform a labor market survey, she has to first identify an occupation then look for employers that may have those occupations, and that requires determining whether there are transferrable skills, and she understood Petitioner's past job was typically unskilled. She explained that was the reason she limited her query to entry-level positions.

The 15 prospective employers were asked if they would hire a person who was wheelchair bound and required sedentary work. However, Ms. Bethell acknowledged that seven of the 15 employers who stated that they would consider hiring a candidate similar to Petitioner also responded that they were not hiring and had no intention of hiring in the future. She noted that Petitioner had home health care assistance three times per week and needed assistance in and out of the shower. She also noted that Petitioner's knee was fused and extended out. However, Ms. Bethell acknowledged that prospective employers were not specifically advised about these facts. She also admitted that they were not informed of Petitioner's narcotic medication needs. Ms. Bethell explained that she was concerned "basically [about] the restrictions and looked at if [Dr. Koehler] mentioned work -- you know, work history." Ms. Bethell also acknowledged that she did not ask prospective employers if they were required to be, or were, totally ADA compliant. She was not asked to assess transportation to work in her analysis, and did not advise prospective employers about Petitioner's transportation circumstances in any way.

Ms. Bethell agreed that Petitioner would need some accommodation in any prospective employment, but also admitted that she did not know Petitioner's education level or her level of computer competency.

On redirect examination, Ms. Bethell testified that it was her company's policy to only talk to representatives of prospective employers who they understand have authority to hire. She believed the companies she contacted were ADA compliant. Ms. Bethell explained that she was to find suitable categories of employment that Petitioner was qualified for, not to find specific employment for Petitioner. On further cross-examination, Ms. Bethell testified that Petitioner was 71 years old at the time of her report.

2. Petitioner's Vocational Evaluation – Ms. Helma (Vocamotive)

On November 9, 2018, Petitioner met with Lisa Helma, Certified Rehabilitation Counselor, from Vocamotive at her attorney's request for a vocational evaluation. Ms. Helma met with Petitioner in her home. She noted that Petitioner was casually dressed and neatly groomed in a motorized wheelchair with her noticeably shorter right leg extended and in a hard, plastic brace. Ms. Helma was provided with the report of Dr. Koehler.

At that time, Petitioner was 71 years old, measuring 5'3.5" and weighing 300 lbs. She sustained a fractured femur for which she had two surgeries: the first to repair the fracture and then a second to remove the hardware and install a spacer and rod after nonunion. Petitioner had bilateral knee replacements in 2000, after which she was off work for three months and was able to return to work without significant difficulties. Petitioner reported her right leg was at least a couple of inches shorter than the left which caused difficulty with balance. Petitioner was released from treatment and no prospective treatment was contemplated. She was unsure whether Dr. Peabody, who last released her from treatment had released her to any kind of work and he had not commented on her restrictions.

With regard to her physical abilities, Petitioner reported difficulty performing activities of daily living and had a caregiver through the state that came three days per week. She had difficulty, or was wholly unable to, dress, groom, or shower without assistance. Her children prepared her food. Petitioner could not stoop, bend, kneel, or crawl. She could not walk to the back of her house without experiencing leg pain or tiredness, and she would be out of breath.

With regard to assistive devices, Petitioner was prescribed a power chair after her second surgery and she was given a hospital bed after leaving rehabilitation. She utilized two braces on her knee, a hard brace that extended from her mid-thigh into her shoe and an immobilizer at night. Petitioner also had benches in her shower and a riser on the toilet. She also purchased a lift chair independently.

With regard to transportation and mobility, Petitioner reported that she purchased a handicap van that allowed her to lift her wheelchair through the back of the van. Petitioner was unable to drive at that time. She reported that she signed up for Pace transportation and that her chair was too large to get into the majority of vehicles. She also reported that she was unable to request which vehicle picked her up, as a result, the Pace transportation was not a viable option for her. In her home, Petitioner had her kitchen doorway widened and her refrigerator moved so that she could access it with her wheelchair. She also had to widen her back doors and install French doors as she was unable to independently open and close the doors. Petitioner also had a portable ramp for her back door.

With regard to her education, Petitioner graduated high school in 1965 with no further education beyond four-to-seven days of training to work as a Traffic Aid. She reported taking "lower classes" in school and difficulty with reading comprehension.

With regard to her work history, Petitioner has a couple of prior part-time jobs selling newspapers by phone and soliciting for bowling leagues. Petitioner was then employed by the City of Chicago, since 1989, initially as a Crossing Guard for children. In 1992, she began working as a full-time Traffic Control Aid directing traffic for the City.

With regard to her socioeconomic status, Petitioner denied looking for work at that time. She reported previously completing 10 applications per week and having taken a test for the City of Chicago, which she failed. She explained that she inaccurately wrote down numbers. She had also brought her resume to the human resource department and completed a profile on the computer.

Ms. Helma found that Petitioner's advanced age affected her ability to adjust to other work. She was also clearly an older worker who had reached the age of retirement, which is perceived as a negative factor in her overall employability. Petitioner also had reported difficulty in reading, spelling, and math. Ms. Helma did not believe that Petitioner had any marketable computer skills and, given her difficulty with schooling, she may struggle with additional training. Ms. Helma identified Petitioner's work experience most closely resembling the Dictionary of Occupational Titles positions of Traffic Officer, Crossing Guard, and Telephone Solicitor.

Ms. Helma determined that Petitioner had no transferable skills given her level of education, previous work experiences, and physical capabilities. She was wheelchair bound, needed assistance getting out of her house, unable to independently open and close doors, dependent on a ramp to get outside of her house, and did not have any reliable mode of transportation. Petitioner's driver's license had expired, and she was unable to utilize Pace transportation services for individuals with disabilities due to an appropriate vehicle not being guaranteed for her; her wheelchair was too large to fit in the majority of vehicles. Ms. Helma noted that this would make commuting for vocational rehabilitation and employment opportunities extremely difficult.

Moreover, Petitioner's motorized wheelchair and fully extended, visibly shorter leg made her disability visible to potential employers. Ms. Helma then noted that the unemployment rate was more than double than for those with a disability than for those without a disability. Moreover, Petitioner had a long work history comprised of her work as a Traffic Aid, which was classified at the medium physical demand level and did not provide Petitioner with any relevant work experience within her current physical capabilities. Petitioner's work as a Telephone Solicitor was many years before, short-term and part-time. Ms. Helma indicated that this work experience was, thus, no longer relevant and she disagreed with Dr. Koehler's assessment that Petitioner could work at a call center or answering phones. In so concluding, she noted that Petitioner would require marketable computer skills and that she would have difficulty performing the essential duties of these occupations given her difficulties with reading and spelling. Ms. Helma also noted that Petitioner had not worked since her injury and this large gap in employment was a negative factor in her overall employability.

Ultimately, Ms. Helma opined that Petitioner had lost access to her usual and customary line of occupation as a Traffic Control Aid. Based on all of the situational factors including her advanced age, level of education, lack of computer skills, previous work experiences, physical capabilities, and lack of transportation options, Petitioner did not have access to any stable labor market and her disability was total.

J. Continued Medical Treatment

On May 6, 2019, Petitioner returned to Dr. Peabody for her last visit. She reported increasing severe pain and was currently on Morphine. Dr. Peabody did not believe she was candidate for replantation of a total knee or for a knee fusion. He advised that if Petitioner's pain became unbearable, amputation would be advisable to alleviate her pain and that it was likely that she would require some form of surgical intervention unless she had some intervening medical problem. Petitioner confirmed that this was her last visit with Dr. Peabody, and to the best of her knowledge he never released her to return to work.

K. Additional Information

Petitioner engaged in further job searches and her job logs reflect approximately 330 entries begin on December 8, 2018 through July 23, 2019. Petitioner testified that she received no job offers.

Petitioner testified that her whole life is different today than just before the accident. She currently she takes six to eight Norco tablets daily, as well as other medications. Petitioner testified that she can no longer work in her prior job, leave the house without assistance, swim, or bowl. She also cannot drive, and shopping is difficult because of the narrowness of the aisles. Petitioner explained that she had to get a hospital bed for her home and also has a woman from the Department on Aging three times a week for four hours a day who prepares meals and helps Petitioner shower, which she is unable to do herself.

II. CONCLUSIONS OF LAW

The Commission affirms the decision of the Arbitrator relating to causal connection, who found that Petitioner's stipulated accident was causally related to the condition of ill-being of her right leg. In so doing, the Arbitrator found "an avalanche of evidence" establishing causation between the accident and Petitioner's right knee condition. Given the agreement by Petitioner's treating physicians and Respondent's Section 12 examiners to this effect, the Commission agrees and affirms this finding.

A. Medical Expenses

With regard to Petitioner's claimed medical expenses, the Arbitrator found that Respondent paid all reasonable and necessary medical expenses, awarding only additional

reimbursement of amounts that she paid to Access Elevator and Extended Home Living. The Arbitrator denied all other claimed expenses. Given the facts and circumstances of this case, the Commission ultimately agrees.

Under the provisions of section 8(a) of the Act, an employer is required to pay for all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of an accidental injury sustained by an employee and arising out of and in the course of her employment. 820 ILCS 305/8(a) (West 2006). An employer's liability under this section of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury. *Second Judicial District Elmhurst Memorial Hospital v. Industrial Comm'n*, 323 Ill. App. 3d 758, 764 (2001) (citing *Efengee Electrical Supply Co. v. Industrial Comm'n*, 36 Ill. 2d 450, 453 (1967)). However, the employee is only entitled to recover for those medical expenses which are reasonable and causally related to her industrial accident. *Second Judicial District Elmhurst Memorial Hospital*, 323 Ill. App. 3d at 764 (citing *Zarley v. Industrial Comm'n*, 84 Ill. 2d 380, 389 (1981)). The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 267 (2011).

On review, Petitioner argues that the maintenance of her wheelchair lift, the widening of her doors, and the modified van were reasonable and necessary expenses compensable under the Act. Respondent correctly notes that the Arbitrator awarded the expenses related to the maintenance of the lift and states that Respondent did not seek review of this award by the Commission. Accordingly, our review is limited to the claimed expenses regarding Petitioner's modified van and the widening of her doors at home.

The costs of remodeling an employee's home, including installing wheelchair lifts and modifying fixtures like bathrooms and stairs, are encompassed in the compensation for work-related injuries contemplated by section 8(a) of the Act. See, *e.g.*, *Zephyr, Inc. v. Industrial Comm'n*, 215 Ill. App. 3d 669, 679 (1991). As Respondent concedes in its brief, the opinion of a physician is not necessary to support such an award, so long as competent evidence establishes the reasonableness and necessity of the award. *Compass Group v. Illinois Workers' Compensation Comm'n*, 2014 IL App (2d) 121283WC, ¶ 46. American courts have offered differing opinions on the issue of awarding a modified van or modifications to a motor vehicle. See, *e.g.*, 8 Larson's Workers' Compensation Law § 94.03 (2020) (and cases discussed therein).

The Commission need not decide in this case whether the award of a modified van is compensable under the Act. The evidence that Petitioner relies upon an unusually-sized, motorized wheelchair to engage in many of the activities of daily life, generally must remain with her leg in an extended position in a hard brace for life, and lacks reliable access to public transportation is relevant to establish the necessity of a modified van. Much of this evidence is also relevant to establish the necessity of the widening of Petitioner's doors to the degree that home modifications are compensable under the Act pursuant to *Zephyr*. However, in this case, Petitioner did not adduce evidence from anyone having knowledge regarding these goods and

services or the usual and customary charges for these disputed items. Accordingly, the Commission finds ample evidence that the van and modified doors were necessary, but affirms the conclusion of the Arbitrator that Petitioner failed to establish that the costs of the modified van and the widening of Petitioner's doors were reasonable.

B. Permanent Disability

The Arbitrator determined that Petitioner was not medically determined to be permanently and totally disabled and, given the facts of the case, a wage differential award was not an appropriate measure of Petitioner's permanent disability. The Commission affirms these findings and turns to the Arbitrator's award of 70% of loss of use of the right leg in contrast to a permanent and total disability (PTD) award. The Arbitrator concluded that Petitioner was not permanently and totally disabled relying on the opinions of Respondent's Section 12 examiner, Dr. Koehler, and Respondent's vocational expert, Ms. Bethell, in denying PTD benefits under and odd-lot theory. The Commission disagrees.

The undisputed facts of this case establish that Petitioner was able to work in a medium-duty capacity standing for hours on end in a full time position as a Traffic Aid for approximately eight years without medical intervention despite bilateral total knee replacements performed in 2000. At the time she was evaluated by Ms. Helma, and Respondent's labor market survey was rendered by Ms. Bethell, Petitioner was a 71-year-old woman with a 1965 high school diploma and one week of training from Respondent. Due to her accident at work, Petitioner underwent two surgeries, a possible third of which is so complicated that both treating and evaluating physicians agreed it would require a highly specialized surgeon to even attempt it, though she might ultimately require an amputation. In addition, Petitioner was prescribed a large, motorized wheelchair and instructed to keep her affected leg in a locked hard-brace and extended at all times (other than showering) to avoid further surgery or amputation as a result of her work-related injury. The fact that Petitioner has no transferrable skills stemming from her work experience is a point on which both vocational counselors agree.

An employee is totally and permanently disabled when she is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Industrial Comm'n*, 77 Ill. 2d 482, 487 (1979). If a claimant's disability is of such a nature that she is not obviously unemployable, or there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove that she fits into an "odd lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that she is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981).

A claimant seeking "odd lot" status must establish it by a preponderance of the evidence. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 373 Ill. App. 3d 1080, 1091 (2007). A claimant ordinarily satisfies her burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that, because of her age, skills, training,

and work history, she will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). Once a claimant establishes that she falls within an "odd lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id*.

In evaluating whether Petitioner has established by a preponderance of the evidence that she is permanently and totally disabled under an "odd lot" analysis, the Commission finds that she has so established whether utilizing the first or second method of proof.

Petitioner has established that she engaged in a diligent, but unsuccessful job search. Petitioner submitted over 80 pages of job search logs on Respondent's sheets listing approximately 490 entries from July 15, 2010 through April 25, 2011. She submitted additional sheets reflecting approximately 330 entries from December 8, 2018 through July 23, 2019. Petitioner testified that she received no job offers. The opinions of Ms. Helma in November of 2018 that Petitioner did not have a stable labor market are buttressed by Petitioner's self-directed job search in 2010-2011 and in 2018-2019. Moreover, no evidence in the record undermines the veracity of Petitioner's job search. Thus, the Commission finds that Petitioner has satisfied her burden to establish that she was permanently and totally disability under an odd-lot theory of recovery by showing diligent, but unsuccessful job searches.

The Commission further finds that Petitioner has established that she was permanently and totally disabled by showing that she will not be regularly employable in a well-known branch of the labor market because of her age, skills, training, and work history. To this end, Petitioner submitted a vocational evaluation report from her certified rehabilitation counselor, Ms. Helma, who opined that Petitioner had lost access to her usual and customary line of occupation. In so doing, she based her opinions on all of the situational factors including Petitioner's advanced age, level of education, lack of computer skills, previous work experiences, physical capabilities, and lack of transportation options. Ms. Helma opined that Petitioner did not have access to any stable labor market, and that her disability was total. Given that Petitioner's age, lack of transferrable skills, extremely limited training, work history, and disability as reflected in the medical records, the Commission finds the opinions of Ms. Helma to be persuasive that Petitioner is totally disabled and a stable labor market is not available to her.

The burden having shifted to Respondent, the Commission notes that Respondent engaged a vocational expert, Ms. Bethell, for the sole purpose of rendering a labor market survey. Ms. Bethell acknowledged the purpose of her engagement by Respondent to render a labor market survey, and the limitations associated with the information made available to her and the tasks that were performed by her, or her colleague, Ms. Egle. She did not meet with Petitioner and had a limited understanding of her medical condition. She based her report solely on the information contained in Dr. Koehler's Section 12 report and was basically concerned with the work restrictions that he would have imposed, and whether there were any references in his report to Petitioner's work history.

Ms. Bethell's discussions with potential employers or her spot checks of Ms. Egle's discussions with potential employers, also leaves much to be desired though primarily because of the limited information available to her and the limited scope of her assignment. Her understanding of Petitioner's physical capabilities was gleaned from Dr. Koehler's report, and does not accurately reflect Petitioner's physical condition or ongoing needs as reflected in the medical records or Petitioner's testimony. Despite admitting that she did not specifically advise the eight prospective employers that were hiring (or the seven that were not) about Petitioner's perpetually extended knee, the dimensions of her wheelchair, or her need for narcotic medications, Ms. Bethell believed that a stable labor market exists for this 71-year-old injured worker with no transferrable skills. Ms. Bethell's conclusion was also reached despite making no assessment of Petitioner's transportation needs to work in her analysis.

Given the lack of information made available to Ms. Bethell, and the notable limitations of Petitioner's condition that MedVoc did, or could, not relay to any prospective employers that were contacted, the Commission does not find that the opinions of Ms. Bethell to be supported by a complete or accurate understanding of the facts in this case. Accordingly, the Commission does not find the opinions of Ms. Bethell to be persuasive, or that Respondent has established that Petitioner is employable in a stable labor market.

The Commission finds that Petitioner has established her entitlement to PTD benefits and awards such benefits.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 15, 2019 is hereby affirmed as modified herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner the sum of $600.32 per week for life pursuant to §8(f) of the Act because the work-related injuries resulted in her permanent and total disablement from gainful employment as of May 6, 2019, the last day she received medical treatment for her work-related injuries.

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

IT IS FURTHER ORDERED BY THE COMMISSION THAT Respondent is not entitled to credit pursuant to §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.

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

/s/*Barbara N. Flores*
Barbara N. Flores

BNF/dw
O-3/4/21
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/s/*Marc Parker*
Marc Parker

Dissent in Part and Concurrence in Part

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator.

Petitioner sustained a severely broken right leg after being struck by an automobile while working directing traffic. She had prior bilateral total knee replacements and the right knee was fused after the accident. The Arbitrator awarded her 150.5 weeks of PPD representing loss of the use of 70% of her right leg. The Arbitrator also awarded her reimbursement for repair of a lift in her home which Respondent had paid for but denied Petitioner's request for reimbursement for installation of French doors in her home and the purchase of a handicapped modified van. The Majority affirmed the Arbitrator's denial of reimbursement for her payment for the van and her payment for installation of French doors. I concur with those aspects of the Majority decision.

On the issue of PPD, the Majority found Petitioner permanently and totally disabled, substantially increasing her PPD award from 150.5 weeks @ 60% of Petitioner's average weekly wage to 500 weeks at 66.7% of her average weekly wage. The Majority relies on the opinion of Ms. Helma, the vocational rehabilitation counselor hired by Petitioner. It is important to remember that no doctor has opined that Petitioner was permanently and totally disabled from employment; they all opined that Petitioner could work at a sedentary physical demand level as was the conclusion of her FCE. Ms. Helma, Petitioner's vocational rehabilitation expert was the only person to opine that Petitioner was permanently and totally disabled. In contrast, Ms. Bethell, Respondent's vocational expert, performed a labor market survey, based on the restrictions imposed by Dr. Koehler, which she believed represented a stable labor market for Petitioner considering her impairments.

In my opinion, the Majority incorrectly relied on Ms. Helma's opinion over that of Ms. Bethell. Apparently, neither vocational rehabilitation counselor was specifically aware that Petitioner had an FCE. However, Respondent's expert was directed to perform her labor market survey based on the restrictions imposed by Respondent's Section 12 medical examiner, Dr. Koehler who used the FCE in arriving at the work restrictions that Ms. Bethell used in her analysis. On the other hand, Ms. Helma did not have such direction and based her conclusions largely on Petitioner's subjective description of her condition. I find the opinions of Ms. Bethell more persuasive than those of Ms. Helma because her opinion coincided more closely to Petitioner's objective condition based on the medical records.

In addition, Petitioner had bilateral total knee replacements prior to the accident and had significant impairment before the work injury. During inpatient physical/occupational therapy a week after the work injury, Petitioner stated "keep in mind that I was only barely functional before this accident even happened." Finally, the Act provides for a specified schedule of awards for injuries to different body parts. The maximum award specified for a leg injury is 215 weeks representing loss of the use of 100% of a leg, which would include an appropriate award for an amputation. I am not aware of any case in which a claimant was awarded permanent and total disability for a leg injury, even if it involved amputation.

Because no doctor has opined that Petitioner was permanently and totally disabled from employment, because Petitioner acknowledged that she was "barely functional" due to her bilateral total knee replacements prior to her instant injury, because I am unaware of any case in which a claimant was awarded permanent and total disability for a knee injury, and because the Arbitrator personally observed Petitioner and had a better sense of the extent of her disability than does the Commission looking only at a transcript, I would have affirmed the Decision of the Arbitrator in denying Petitioner claim of permanent and total disability and affirmed his PPD award.

For the reasons stated above I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I concur in part with, and respectfully dissent in part from, the Decision of the Majority.

DLS/dw
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/s/*Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STALNAKER, JUDY N Case# **08WC010108**
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

On 11/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1293 VITELL & SPITZ LTD
EDWARD SPITZ
155 N MICHIGAN ACE SUITE 600
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Judy N. Stalnaker
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **08** WC **10108**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **June 27, 2019; July 23, 2019; and August 26, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident 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 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*** 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 $**46,824.96**; the average weekly wage was $**900.48**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services, and is awarded certain compensation for lifestyle modifications.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services, but not for lifestyle modifications.

Respondent shall be given a credit of $**131,298.56** for TTD, $**0** for TPD, $**225,891.84** for maintenance, and $**0** for other benefits, for a total credit of $**357,190.40**.

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

ORDER

Medical benefits

Respondent shall pay or reimburse Petitioner for reasonable and necessary home or lifestyle modifications of $3432.28 to Access Elevator and $1054.48 to Extended Home Living.

Maintenance

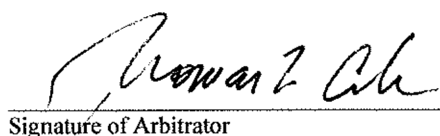
No maintenance benefits are awarded.

Permanent partial disability

Respondent shall pay Petitioner permanent partial disability benefits of $540.29 per week for 150.5 weeks because the injuries sustained caused the 70% loss of the right leg, as provided in Section 8(e) of the Act.

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

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



Signature of Arbitrator

Date

NOV 15 2019

Judy N. Stalnaker v. City of Chicago, No. 08 WC 10108

Preface

The parties proceeded to hearing June 27, 2019, on a Request for Hearing indicating the following issues in dispute: whether Petitioner's current condition of ill-being is causally connected to an injury sustained January 31, 2008; whether Respondent is liable for unpaid medical bills; whether Petitioner is entitled to maintenance; and what is the nature and extent of the injury. The hearing was recessed to July 23, 2019, and proofs were closed. Petitioner's motion to reopen proofs was granted over objection. Evidence in the form of testimony from Petitioner and job search logs were received and proofs closed August 26, 2019. No transcripts were ordered. Petitioner testified. The testimony of Jacqueline Bethell and Dr. John Koehler were received via evidence deposition. Arbitrator's Exhibit 1; Arbitrator's Exhibit 3.

Findings of Fact

Judy Stalnaker (Petitioner), a 60 year old female, testified that on January 31, 2008, she was a traffic aide with the City of Chicago (Respondent), directing traffic at Clark and Jackson. She was hit by a taxi and thrown to the ground. She testified she was taken by ambulance to Northwestern Memorial Hospital.

The written records of Northwestern Memorial are largely illegible. What can be gleaned is that Petitioner sustained a traumatic femur fracture, a severely comminuted fracture of the right distal femur at the level of knee prosthesis. Petitioner had previous bilateral total knee replacement in 2000. On February 1, 2008, Petitioner had surgery, an open reduction and internal fixation of the right distal femur; and local and supplementary bone grafting. A physical therapy progress note from February 7, 2008, notes Petitioner told Paul Witte, "Keep in mind I was only barely functional before this accident ever happened." At the time, she was 5 feet 5 inches, 300 pounds. Petitioner's Exhibit 1; Petitioner's Exhibit 5.

Petitioner testified she was transferred to the Rehabilitation Institute of Chicago, then to a nursing home, then back to the Rehabilitation Institute of Chicago. She was discharged April 29, 2008, to her home. Petitioner's Exhibit 3.

Petitioner testified she received a Functional Capacity Evaluation. The records of Northwestern Center for Orthopedics indicate such evaluation was done January 7, 2009, by Workstrategies, Novacare Rehabilitation Oak Lawn. Petitioner was currently functioning in a light physical demand work category, which was considered her true functional capacity. Petitioner's Exhibit 3.

In January 2010, Dr. Scott Cordes of Northwestern placed Petitioner at MMI and a candidate for light duty. In January 2009, he noted Petitioner should not ever return as a traffic aide, but could do light duty. Petitioner's Exhibit 3.

Petitioner testified she conducted a job search. The search indicated she contacted 480 employers from July 2010 through April 2011. She received no job offers. Petitioner's Exhibit 4a.

Petitioner was seen in 2001 and 2013 at Midwest Orthopaedics at Rush. Their records indicate Dr. Christopher DeWald found Petitioner's symptoms of pain and difficulty with ambulation related to the injury and strongly recommended a rehabilitation specialist. Dr. Walter Virkus examined Petitioner in a scooter because she could not walk. He found a non-union of her fracture. Dr. Stephen Gitelis noted Petitioner had a complex and limb threatening orthopaedic condition, a severe fracture of the lower end of her femur around a total knee arthroplasty, a condition too complicated and too unusual to take a chance with her limb. He recommended surgical reconstruction at the Mayo Clinic. Petitioner's Exhibit 7.

Petitioner submitted to an independent medical examination by Dr. Rajeev Garapati of Illinois Bone and Joint September 24, 2012. Garapati noted Petitioner's injury was at work January 31, 2008, and her prior bilateral total knee replacement in 2000. He indicated Petitioner injured her right distal femur, had surgery, then difficulty and pain to her right lower extremity. He noted Petitioner's bone was slow to heal and there was a shortening of the lower extremity. Garapati noted Dr. Walter Virkus indicated the non-union of that area and recommended distal femoral replacement. He said Petitioner could not walk any significant distance and had difficulties with activities of daily living. Garapati indicated Petitioner had a non-union with angulation, bone loss and shortening of her right distal femur. He recommended further surgical intervention and Petitioner's prognosis would be fair. Without surgery, her prognosis would be very poor. Garapati said Petitioner's current status and the injury she sustained are directly related to the injury of January 31, 2008. The fracture never healed. He found few options and recommended distal femur replacement with a hinged knee prosthesis. He found Petitioner not at MMI, but could return to work in a sedentary desk job. Petitioner's Exhibit 5.

Petitioner suffered numerous non-related medical issues for a period of time before undergoing surgery April 16, 2015, at Northwestern Memorial Hospital. Dr. Terrance Peabody performed a resection, failed hardware, placement of antibiotic cement spacer. His diagnosis was non-union right distal femur periprosthetic, femur fracture infected total arthroplasty right.

Petitioner submitted to an independent medical examination by Dr. John Koehler. Koehler testified he is board certified in occupational medicine. His practice treats work related injuries. He said he did an examination of Petitioner March 8, 2018. He said Petitioner spends most of her time in a high tech wheelchair. His physical examination noted Petitioner as quite overweight, with swollen legs. Her fixed leg was problematic for ambulation. He diagnosed her with a lengthy host of medical problems with fused knee and bleeding complications related to the work accident. He said Petitioner could not return to a job as a traffic control aide, but could return to other work. Koehler said Petitioner was incapable of being out of her wheelchair for any length of time. He said Petitioner reached MMI, had no prospects for improvement, and was not a further surgical candidate. Respondent's Exhibit 1.

Jacqueline Bethell, a certified rehabilitation consultant, testified she was asked by Respondent to do a labor market survey and did so June 5, 2018. She was asked to provide an

opinion as to Petitioner's work capabilities based on Dr. Koehler's IME. She said she looked at Petitioner's work history and current physical capabilities per Dr. Koehler. She spoke to potential employers and in her opinion a stable labor market existed for Petitioner and her wheelchair could be accommodated. She testified she never met Petitioner, and did not know if she had done a job search. Her report indicated jobs exist in the general labor market that an injured worker can do even with restrictions, if she chose to look for work. Respondent's Exhibit 2.

Lisa Helma of Vocamotive was asked by Petitioner's attorney to render an opinion on the employability of Petitioner. Helma's Initial Evaluation Report, done November 9, 2018, noted Petitioner was 71 years old and had two surgeries on her right femur, and had no range of motion in her right knee. She no longer participates in physical therapy or occupational therapy, as her doctor said it was not beneficial. Helma was not sure if Petitioner was released for work. Even though Petitioner had received a function capacity evaluation in 2009, Helma said Petitioner had not completed one. Helma said Petitioner was a high school graduate, was a crossing guard and traffic control aid since 1989, and had no licenses, certifications, or skills. Petitioner denied currently looking for work. She said Petitioner had no transferrable skills, was wheelchair found, and mentally sharp. She thought Petitioner had lost access to her usual and customary line of occupation and had no access to a stable labor market, her disability was total.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill-being causally related to the injury. An injured employee bears the burden of proof to establish the elements of her right to compensation, including the existence of a causal connection between her condition of ill-being and her employment. Navistar International Transportation Corporation v. Industrial Commission (Diaz), 315 Ill. App. 3d 1197, 1202-1205 (2002). A claimant must prove that some act or phase of her employment was a causative factor in the ensuing injury. Whether a causal connection exists is a question of fact. Vogel v. Illinois Workers' Compensation Commission, 354 Ill. App. 3d 780, 786 (2005).

I find as a conclusion of law, Petitioner's current condition of ill-being causally related to the injury she suffered January 31, 2008, when she was struck by a taxi while on duty as a traffic aide. There is an avalanche of evidence in support of such finding, and none in the testimony or evidence submitted to support Respondent's dispute of such a claim in the Request for Hearing.

I specifically rely on the records of Northwestern Hospital; the records of Dr. Christopher DeWald of Midwest Orthopaedics at Rush; the independent medical examination of Dr. Rajeev Garapati; and the testimony of Dr. John Koehler. Petitioner's Exhibit 1; Petitioner's Exhibit 7; Petitioner's Exhibit 5; Respondent's Exhibit 1.

Disputed issue **J** is whether Respondent is liable for unpaid medical bills to: Mobility Works; Access Elevator; Window Works; Extended Home Living Services; and Northwestern Medical. As to Northwestern Medical in the amount of $30.00, there is no support for such claim and so it is denied.

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. There is nothing in the Act that precludes or includes compensation for home or lifestyle modifications. Nevertheless, there is support for an employer's obligation to pay for such things as home modifications. There is no requirement that the opinion of a physician is necessary to support an award regarding home modifications; however, there must be competent evidence establishing the reasonableness and necessity of that award. Compass Group v. Illinois Workers' Compensation Commission, 2014 Ill. App. (2d) 121283 WC P 44; P 46.

Here Petitioner seeks $42,160.0 for her purchase of a 2015 used Dodge Grand Caravan. Petitioner's Exhibit 12. Petitioner testified simply she bought it and was not reimbursed. Dr. Koehler testified Petitioner would have to have a custom manufactured vehicle with hand controls to drive, she could not drive just a van that could take her wheelchair. Respondent's Exhibit 1. There was no evidence this was such a vehicle. Moreover, the Initial Evaluation Report of Vocamotive states twice, Petitioner is unable to drive and then says she has no driver's license. There was no evidence presented by Petitioner that showed such purchase was reasonable or necessary.

Petitioner testified she was eligible for complimentary paratransit services from Pace. Petitioner's Exhibit 11. There was no testimony she could not ride public transportation. Such award is denied.

Petitioner seeks $3,432.28 and $1,054.48 for work done on a lift at her home. Petitioner's Exhibit 13; Petitioner's Exhibit 16. She testified as to why the work was done. Dr. Scott Cordes at Midwest Orthopaedics noted Petitioner had to obtain a lift at her home before beginning outpatient therapy. Petitioner's Exhibit 7. I believe the lift was reasonable and necessary and award these amounts.

Finally, Petitioner seeks $3,991.00 for a bill from Window Works. Petitioner's Exhibit 14. Petitioner testified it was for installation of a French door to move her wheelchair through. The Initial Evaluation Report from Vocamotive indicates Petitioner's back doors were replaced with French doors, because Petitioner was unable to independently open and close the doors. Petitioner's Exhibit 8. That, however, had come from Petitioner, who failed to testify at trial about the reasonableness and necessity of the expense. The installation leaves Respondent with an unfair *fait accompli*. I find the evidence fails to establish the reasonableness or necessity of such award. Such award is denied.

Disputed issue **K** is whether Petitioner is entitled to maintenance benefits from April 1, 2009, through November 29, 2013, and from December 10, 2016, through June 27, 2019. Petitioner fails to acknowledge or address this issue raised in her Request for Hearing in Petitioner's proposed decision and findings of fact and conclusions of law.

Employers are obligated to pay for treatment, instruction, and training necessary for the physical, mental, and vocational rehabilitation of an employee, including all incidental maintenance costs and expenses. Employers are obligated to pay maintenance only when a

claimant is engaged in a prescribed rehabilitation program. Euclid Beverage v. Illinois Workers' Compensation Commission, 2019 Ill. App (2d) 18009 WC, P 29; 820 ILCS 305/8a. Maintenance is a component of vocational rehabilitation, specifically provided for in the Act. It is generally awarded after an employee proves she is entitled to vocational rehabilitation. Plainly read, Section 8(a) sets forth the fiscal obligations of an employer under the Act to provide maintenance benefits to an employee undergoing vocational rehabilitation. Roper Contracting v. Industrial Commission (Grabis), 349 Ill. App. 3d 500, 505 (2004).

There was no testimony or evidence Petitioner was ever engaged in a vocational rehabilitation program. I find Petitioner not entitled to a period of maintenance.

Disputed issue **L** is what is the nature and extent of the injury. Petitioner suffered a severe fracture of the lower end of her right femur around a previous total knee arthroplasty. The hardware installed failed, there was a non-union of the femur. There was a shortening of her lower extremity. Petitioner has had two surgeries. Her right knee has fused. She wears a long leg orthosis and is wheelchair bound. Her condition is permanent. Dr. John Koehler testified. Petitioner is at MMI.

Petitioner suggests she is totally disabled and seeks permanent total disability benefits falling into the odd lot category for an award pursuant to 820 ILCS 305/8(f). Respondent suggests Petitioner sustained a loss of trade and permanent partial disability should be based on a man as a whole.

Permanent partial disability is awarded if a job related injury results in some permanent physical loss. There are four types of permanent partial disability: a wage differential where an employee obtains a job paying less than the pre-injury employment; a value on certain body parts, where amputation represents a 100% loss; a value of nonlisted body parts based on the loss of a person as a whole; and disfigurement. 820 ILCS 305/8(d)1; 8(e); 8(c); 8(d)2.

Permanent total disability is, in part, a complete disability that renders an employee permanently unable to do any kind of work for which there is a reasonably stable employment market. 820 ILCS 305/8(f).

To qualify for a wage differential under Section 8(d)1 of the Act, a claimant must prove partial incapacity which prevents her from pursuing her usual and customary line of employment; and impairment of earnings. To prove an impairment of earnings, a claimant must prove her actual earnings for a substantial period before the accident and after she returns to work, or in the event she has not returned to work; what she is able to earn in some suitable employment. Crittenden v. Illinois Workers' Compensation Commission, 2017 Ill. App. (1st) 160002 WC P 20.

Here, there is evidence from Dr. John Koehler, that Petitioner cannot return to her job as a traffic control aide. Respondent's Exhibit 1 at 13. Dr. Scott Cordes said the same thing in January 2009. Petitioner's Exhibit 3. However, here there is not enough evidence upon which to conclude an impairment of earnings. The parties have stipulated the average weekly wage preceding the injury was $900.48. Arbitrator's Exhibit 1. Since Petitioner has not returned to

work, what would Petitioner be able to earn in suitable employment. Jacqueline Bethell testified that if prospective employers who would consider hiring Petitioner, the mean entry level wage was $10.98 per hour. There was no consistent wage reflected in the Labor Market Survey. Respondent's Exhibit 2 at 9; Exhibit 2. Moreover, Petitioner offers evidence she has no access to a stable labor market. Petitioner's Exhibit 8.

A wage differential is not an appropriate measure of benefits in this case.

Section 8(d) 2 provides for a man as a whole award where a Claimant sustains serious and permanent injuries not covered by Sections 8(c) and 8(e). Village of Deerfield v. Illinois Workers Compensation Commission, 2014 Ill. App. (2d) 131202 WC P 51.

Such measure of benefits is not appropriate to her because Petitioner's injury to her right leg is covered in Section 8(e). The serious and permanent injury here is to Petitioner's right leg. Petitioner's Exhibit1A at 37; Petitioner's Exhibit 7; Petitioner's Exhibit 1C; Petitioner's Exhibit 5.

An employee is permanently and totally disabled if she is obviously unemployable, that is unable to make some contribution to industry sufficient to justify the payment of wages, or there is medical evidence to establish a claim of permanent and total disability. If an employee's disability is limited and it is not obvious the employee is unemployable, the employee may demonstrate entitlement to permanent total disability by proving she fits into an odd lot category, consisting of employees who, while not altogether incapacitated for work, are so handicapped that the will not be employed in any well known branch of the labor market. Fulfilling the burden of establishing an odd lot category can be done by: showing a diligent but unsuccessful search for employment; or by demonstrating that because of age, training, education, experience, and condition, there are no available jobs for a person in her circumstance. If such a showing is made, the employer must show some kind of suitable work is available to the employee. Pisano v. Illinois Workers' Compensation Commission, 2018 Ill. App. (1st) 172712 WC P 73.

Here, Petitioner testified she looked for work in 2010 and 2011 and also in 2018 and 2019. Petitioner's Exhibit 4A; 4B. At nearly the same time, Petitioner retained Vocamotive for an opinion on her employability. Vocamotive, in a report, did not know if Petitioner had been released to work, or had any treatment or testing planned, and said Petitioner had no access to a stable labor market. In a conspicuous failing, Vocamotive indicated Petitioner had not completed a functional capacity examination. In fact, she had, in January 2009 with Workstrategies, in which Petitioner's true functional capacity was placed at the light level. Petitioner's Exhibit 3.

In contrast, Dr. John Koehler, a board certified doctor in occupational medicine, met Petitioner, reviewed her medical records, and physically examined her, found Petitioner could return to work other than as a traffic aide. He noted: she was mentally sharp, her faculties at 100%; her wheelchair was very effective; and had reached MMI. Respondent's Exhibit 1.

Jacqueline Bethell of MedVoc Rehabilitation, Ltd. testified she did a labor market survey including Petitioner's work capabilities based on Dr Koehler's examination. She contacted

prospective employers who indicated they would consider Petitioner, and could accommodate her in sedentary work. In her opinion, a stable labor market exists for Petitioner. Respondent's Exhibit 2.

I also note the opinion of Dr. Garapati on September 24, 2012, that Petitioner could return to work in a sedentary capacity, as well as Dr. Corders on January 20, 2009, that Petitioner could do light duty with a sitting job. Petitioner's Exhibit 5; Petitioner's Exhibit 3.

I find Dr. Koehler, Dr. Garapati, Dr. Corders, and Ms. Bethell in a superior position to Vocamotive on this issue, and rely on them to find as a conclusion of law Petitioner is not permanently and totally disabled, and does not fit an odd lot category.

This leaves permanent partial disability based on a body part, Petitioner's right leg, pursuant to Section 8(e)12. This accident occurred after February 1, 2006. Here, the date of injury predates the establishment of criteria in 820 ILCS 305/8.1b, and so disability need not be established using those criteria.

Petitioner spends most of her time in a wheelchair. Her fixed right leg, slightly flexed and fused, is a permanent condition making it problematic for ambulation. It seems her weight is keeping her from being able to ambulate. She wears a long orthosis, a brace, at all times.

Loss of a member is complete when the normal use of the member has been taken away. Illinois Bell Telephone Co. v. Industrial Commission, 265 Ill. App. 3d 681, 687 (1994). When Section 8(e) of the Act employs the term "loss", it means amputation, severance, or complete loss of use of the affected member. It can be a total or partial loss. Outboard Marine Corp. v. Industrial Commission (Rivord), 309 Ill. App. 3d 1026, 1029 (2002). Petitioner's loss as to her right leg is not a complete loss. I base this on Dr. Koehler's unrebutted testimony that Petitioner could walk if she were 150 pounds lighter. Respondent's Exhibit 1 at 13-14. I do, however, recognize the difficulty of weight loss in someone of Petitioner's situation.

Based on the evidence, the testimony of the witnesses, and a careful consideration of the record as a whole, I find Petitioner sustained permanent partial disability to the extent of seventy (70) % loss of use of the right leg (150.5 weeks).

Arbitrator

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC010089
Case Name	JONES,JAMES T v. BIG DADDY SCRAP
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arb
Decision Type	Commission Decision
Commission Decision Number	21IWCC0215
Number of Pages of Decision	17
Decision Issued By	Stephen Mathis, Commisioner

Petitioner Attorney	John Cronin
Respondent Attorney	Peter Havighorst

DATE FILED: 4/29/2021

/s/ *Stephen Mathis, Commissioner*

Signature

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

James T. Jones,

Petitioner,

vs. NO. 17WC010089

Big Daddy Scrap,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 2020 is hereby affirmed and adopted.

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

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

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

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

APRIL 29, 2021

/s/*Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-4/7/2021
44

/s/*Deborah Baker*
Deborah Baker

/s/*Deborah Simpson*
Deborah Simpson

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

JONES, JAMES T
Employee/Petitioner

Case# **17WC010089**

BIG DADDY SCRAP
Employer/Respondent

On 2/10/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0146 CRONIN PETERS & COOK PC
JOHN J CRONIN
19 S LASALLE ST SUITE 1202
CHICAGO, IL 60603

1139 NOBLE & ASSOCIATES PC
MICHAEL T CHALCRAFT II
4355 WEAVER PKWY SUITE 340
WARRENVILLE, IL 60565

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JAMES T. JONES,
Employee/Petitioner
v.
BIG DADDY SCRAP,
Employer/Respondent

Case # **17** WC **10089**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **ROBERT M. HARRIS**, Arbitrator of the Commission, in the city of **CHICAGO**, on **December 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. ☐ 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 **FUTURE MEDICAL**

FINDINGS

On the date of accident, **1/23/17**, 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 $**29,120.00**; the average weekly wage was $**560.00**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $**27,257.12** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**27,257.12**.

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

ORDER

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILTY BENEFITS OF $373.33 PER WEEK FOR A PERIOD OF 148-4/7 WEEKS, COMMMENCING JANUARY 24, 2017 THROUGH DECEMBER 2, 2019, AS PROVIDED IN SECTION 8(b) OF THE ACT.

RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES, PURSUANT TO SECTIONS 8(A) AND 8.2 OF THE ACT, AS FOUND IN PX 1, OF $16,025.00 TO LIBERTY PHYSICAL THERAPY AND $989.00 TO DR. IHM. RESPONDENT SHALL FURTHER REIMBURSE EQUIAN $6,285.44 FOR SUBROGATION OF MEDICAL BILLS PAID BY MEDICAID.

RESPONDENT SHALL PAY FOR FUTURE MEDICAL TREATMENT AS ADDRESSED BY PETITIONER'S TREATING PHSICIANS.

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.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

February 3, 2020
Date

FEB 10 2020

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS AND CONCLUSIONS OF LAW

On January 23, 2017 Petitioner was working as a foreman Respondent for Big Daddy Scraps, which operated as a recycling plant. Petitioner had been employed for one year and two months. The duties of a foreman are to resolve the problems that arise in the running of the plant. The job was very physical and involved heavy lifting of various amounts.

On January 23, 2017 a mechanic called Petitioner to help remove a flat tire on one of the trucks. Petitioner took a 3-foot-long breaker bar and placed it on one of the lug nuts. Petitioner applied as much pressure as he could when the breaker bar broke and he fell to the ground. Petitioner noticed immediate pain in his back and down both legs. Petitioner testified his legs were not working but eventually was able, with assistance, to stand up. Petitioner's boss Michael Spitole was present.

Petitioner testified he never had any problem with his back or legs prior to January 23, 2017. Tr. 19) Petitioner also testified he never had any prior worker's compensation claim.

Petitioner was contacted the next day by his boss. Petitioner was then sent to Homer Chiropractor by his employer.

Petitioner commenced treatment at Homer Chiropractic on January 26, 2017 and completed treatment February 23, 2017 (Pet. Ex. #2). This treatment provided no relief.

The worker's compensation carrier then referred Petitioner to Parkview Orthopedics. Petitioner came under the care of Dr. Sandport and Pain specialists Dr. Hussein. An MRI was ordered and performed on March 9, 2017. The MRI revealed a small extruded disc at L4-L5 and bulging annular tear at L5-S1. (Pet. Ex. No. 3)

Dr. Sandport ordered an epidural injection which provided no relief.

On April 25, 2017, Dr. Sandport gave Petitioner three options. Undergo physical therapy, have more injections or see a specialist at Northwestern Medical Center. Petitioner chose the third option and came under the care of Joseph Ihm, M.D.

On June 30, 2017 Dr. Ihm evaluated the Petitioner. Dr. Ihm initially ordered more therapy at Physical Therapy and Spine. (Pet. Ex. No. 4)

Petitioner underwent treatment at Physical Therapy and Spine. (Pet. Ex. No. 6) This treatment also did not relieve Petitioner's pain.

Dr. Ihm then discussed seeing a spine surgeon. Petitioner was referred to Wellington Hsu M.D. by Dr. Ihm and the workers' compensation carrier. This evaluation did not occur until November 25, 2017. Dr. Ihm and Petitioner reviewed Dr. Hsu's report which Dr. Ihm disagreed. Dr. Ihm then referred Petitioner for further treatment to George Cybulski, M.D., who was a neurosurgeon. Petitioner continued to remain off work.

Prior to referring Petitioner to Dr. George Cybulski, Petitioner was referred to Brightmore Physical therapy for a functional capacity exam. (PX 7) Physical therapist David W. Brightmore performed the evaluation. This was a one-day "Workwell Standard FCE Physical Exam." This exam was performed on February 5, 2018. The exam noted multiple findings in the "Summary of Physical Assessment", including "positive straight leg raise left with reproduction of left lower extremity symptoms." The evaluator indicated "All Waddell signs were negative." [**Arbitrator's Note**: This FCE finding was in direct contrast to the opinions of Respondent's Section 12 examiner Dr. Ghaneyem, who noted "findings consistent with symptom magnification". As noted below, the Arbitrator does **not** credit Dr. Ghanayem's opinions herein]. The FCE evaluator also found absent left patella and Achilles reflex. Under the "Effort and Cooperation" section, the evaluator indicated, "1. Client was **100% cooperative** in that he willingly participated in all FCE subtests. 2. Client demonstrated a **strong, but submaximal effort**, as his pain was not well controlled and limited his progressions and effort." (all emphasis in original record). The evaluator noted Petitioner demonstrated both "inconsistent" and consistent" performance. The evaluator also indicated "Client's dysfunction was 100% consistent in all physical exam testing and also functional testing. He has a very low functional level at this time."

After this FCE, Petitioner experienced so much pain that he was bedridden for several weeks.

On March 12, 2018, Petitioner came under the care of neurosurgeon George Cybulski, M.D. Dr. Cybulski prescribed a follow up MRI.

On May 14, 2018, the follow up MRI was reviewed Dr. Cybulski. Dr. Cybulski noted L4-L5 disc herniation with extrusion to the right and left sided leg pain.

Dr. Cybulski prescribed an L4-L5 microdiscectomy and found conservative measures had failed Petitioner. (Pet. Ex. No. 8)

On June 14, 2018, Petitioner was examined by Alexander Ghanayem, M.D. at the request of Respondent pursuan to Section 12.

Dr. Cybulski was deposed on May 2, 2019. (Pet. Ex. No. 9) Dr. Cybulski testified the preoperative diagnosis was bilateral L4-L5 radiculopathy secondary to L4-L5 left sided herniated disc, right L4-L5 foraminal stenosis. (Pet. Ex. No. 9, p. 16)

Dr. Cybulski testified his clinical exam was consistent with sciatica due to irritated lumbar nerve root. (Pet. Ex. No. 9, p. 9) The initial MRI revealed a herniated disc at L4-L5. Dr. Cybulski then ordered a follow up MRI that took place on March 23, 2018. (Id, p. 10) Dr. Cybulski testified that MRI was reviewed with Petitioner on May 14, 2018 and his interpretation of this MRI also revealed a lumbar disc herniation at L4-L5. (Id. p. 11)

Dr. Cybulski testified that Petitioner had undergone conservative treatment with Dr. Joseph Ihm at the Shirley Ryan Institute and failed to respond. Petitioner continued to remain off work. (id., p. 14)

Lumbar surgery was finally performed on April 24, 2019. Dr. Cybulski's testified that in layman's terms he made room for the nerve roots on both sides of the L4-L5 level of the spine. Dr. Cybulski then excised herniated disc material from the left side and specifically stated that the nerve root was compressed on both sides. (Id., pp. 16-17)

Dr. Cybulski testified that he reviewed surveillance of Petitioner. Surveillance took place on October 18, 2018 and October 24, 2018. (Id., p. 18) Dr. Cybulski testified he did not see anything in the surveillance video that seemed inconsistent with his physical examinations of Petitioner in the course of his treatment. (Id., p. 30) Dr. Cybulski further testified he did not see anything in the surveillance video that made him think that Petitioner was magnifying his symptoms. (Id., p. 30-31) [**Arbitrator's Note**: The Arbitrator agrees with Dr. Cybulski's assessment of the value and significance of the surveillance video, which the Arbitrator viewed and finds and concludes it carries minimal evidentiary value.]

Dr. Cybulski also testified that histories of Petitioner's work injury that were provided to the prior doctors were consistent with the history that Petitioner presented to Dr. Cybulski. (Id. p. 14)

Dr. Cybulski testified that based on all the information provided that Petitioner's diagnosis was an L4-L5 herniated disc with radiculopathy. (Id. P. 20). Dr. Cybulski further opined that based on a review of the medical records presented, including the MRIs and the mechanism of injury that Petitioner's current related condition is causally related to the work injury he suffered on January 23, 2017. (Id. P. 20).

The basis of the opinion is how Petitioner was basically utilizing his back with a wrench of some sort to dislodge an object, the wrench or bar broke and after that he experienced the lumbar radicular symptoms that I evaluated him for. (Id., p. 20)

Dr. Cybulski further that the surgery that was performed was result of the injury and he will require further medical care as a result of that surgery. (Id., p. 21)

Dr. Cybulski also testified that a "structural injury" to Petitioner's spine occurred at the time of his injury and that the Petitioner was asymptomatic prior to the injury at work. (Id., p. 22) This was in direct contradiction the opinions of Dr. Ghanayem, who opined that at worst a sprain/strain occurred.

Dr. Cybulski reviewed Dr. Ghanayem's report and he "respectfully disagreed" with Dr. Ghanayem's opinions. (Id. p. 23). This was based on Dr. Cybulski's "evaluation of all the MRI scans, my seeing Mr. Jones on a number of occasions and examining him." (Id. p. 23).

Dr. Cybulski again testified that during surgery he found compressed nerves at L4-L5 level for the herniated disc. (Id. p. 23). Dr. Cybulski testified he never saw any symptom magnification in his care and treatment of Petitioner. (Id. pp. 23-24). and that there was no symptom magnification in his care and treatment of Petitioner. [Arbitrator's Note: Dr. Ghanayem was the only medical professional who reported any symptom magnification.]

Lastly, Dr. Cybulski testified he noted abnormalities on the MRI films he reviewed, notably a herniated disc at L4-5 and a degenerated disc at L5-S1. (Id. p. 24) Dr. Cybulski testified that (herniated) disc would be consistent with the mechanism of injury that was described to him. (Id. p. 24).

Dr. Alexpander Ghanayem testified in his deposition on July 10, 2019. (Resp. Ex. No. 2) Dr. Ghanayem testified he reviewed the MRI film of March 2018 and the MRI did not show any disc compression. (Id., p. 14) Dr. Ghanayem opined the complaints were non-surgical because the MRI did not show any pinched nerves and the work injury was a soft tissue injury. (Id., p. 15 – 18)

Dr. Ghanayem had one visit with Petitioner on June 24, 2018 and had no independent recollection. (id., p. 21) Dr. Ghanayem testified that Petitioner was asymptomatic prior to the injury. (Id, p. 23) Dr. Ghanayem stated in his summary that Petitioner did not seek immediate care. When confronted with the fact that Petitioner sought treatment three days after the injury, Dr. Ghanayem said that was a non-issue for him. (Id., p. 23)

Dr. Ghanayem did not dispute that Petitioner provided consistent histories to all the doctors with whom he treated. (Id., p. 24) Dr. Ghanayem testified that he agreed the history of taking off a lug nut when the bar broke could be a competent cause of injury. (Id., p. 25)

Dr. Ghanayem testified he could not recall any other doctor concluding Petitioner was magnifying his symptoms. (id., p. 28)

Dr. Ghanayem testified he never reviewed the surgical report and has not done any other work on this case since June 2018 and the fact that Dr. Cybulski found a herniated disc at L4 and L5 and that the nerve root was compressed. Dr Ghanayem testified he has not seen the report so he cannot comment. (Id., p. 30)

Regarding his theory of causation and the finding of a herniated disc during surgery, , Dr. Ghanayem testified "It's more likely that there's an intervening accident that cause the disc herniation than me being wring in my assessment of the patient...so the more likely answer is something else happened after the fact..." (Id. p. 32). [Arbitrator's note: There is no evidence in the record to suggest, let alone indicate, any intervening trauma to explain the presence of the herniated disc. Therefore, Dr. Ghanayem has engaged in speculation to support his denial of causation.]

Petitioner at the hearing testified that there never was any subsequent injury to his low back since the accident of January 23, 2017. (Tr. 48). That testimony was never rebutted.

Petitioner further testified that following surgery that his leg pain was gone and that his legs no longer gave out. Petitioner is now attending therapy and his strength is returning. Petitioner continues to complain of back pain where at the surgical site. Petitioner testified he does not sleep at night. Petitioner has follow-up medical visits with Dr. Joseph Ihm and Dr. Cybulski's group and is still taking medication.

CONCLUSIONS OF LAW

F. In support of the Arbitrator decision as to whether the Petitioner's condition of ill-being causally related to the injury, the Arbitrator makes the following findings and conclusions:

The Arbitrator adopts and incorporates the Statement of Facts above into all Sections that follow below. The Arbitrator finds and concludes Petitioner was a credible witness; his testimony

was not challenged - let alone rebutted - by any witness and his testimony is overall supported by the records in evidence. No credible evidence was presented in the record to establish that Petitioner's trial testimony was not credible nor that the histories he provided as noted in the record were not credible.

The Arbitrator specifically discounts the opinion of Dr. Ghanayem that Petitioner "...has multiple nonorganic physical exam findings consistent with symptom magnification." (Resp. Dep. Ex. 2). The Arbitrator further specifically discounts the statement of Dr. Ghanayem where he actually questioned whether Petitioner sustained an accident: "If he did sustain an injury..." (Resp. Dep. Ex. 2, p. 2).

The Arbitrator specifically discounts the opinion of Dr. Ghanayem regarding his theory of causation and the finding of a herniated disc during surgery. Dr. Ghanayem testified "It's more likely that there's an **intervening accident** that caused the disc herniation than me being wrong in my assessment of the patient...so the more likely answer is something else happened after the fact..." (Id. p. 32). As noted above, **there is no evidence in the record to suggest, let alone indicate, any intervening trauma to explain the presence of the herniated** disc (and, again, Petitioner credibly denied any post-accident low back trauma, which was never rebutted). Therefore, **Dr. Ghanayem engaged in speculation to support his denial of causation**. These are additional examples of the bases as to why the Arbitrator has discounted Dr. Ghanayem's opinions and instead places full weight and credibility on the opinions of Petitioner's treating physician Dr. Cybulski.

Petitioner's testimony stands unrebutted that he was not experiencing any symptoms prior to his injury at work on January 23, 2017 and that he sustained no subsequent low back trauma after the stipulated injury.

Petitioner's credible testimony detailed how with as much force as he could deliver he attempted to loosen a lug nut with a breaker bar. When the breaker bar broke Petitioner fell to the ground. Upon falling to the ground, he immediately felt sudden and intense pain from his back down back legs. The evidence is clear that he has undergone consistent and ongoing medical care since his injury at work. He was still under active medical care at this time of his hearing.

Proof of the state of health of an employee prior to and down to the time of injury and the change immediately following the injury and continuing thereafter is competent as tending to establish that the impaired condition was due to the injury. *Kress Corp. v. Industrial Commission*, 190 Ill. App. 3d 72, 82 (1989). This is the "chain of events" theory. This theory is also applicable in this

claim. Therefore, comparing Petitioner's medical condition prior to January 23, 2017 and comparing his condition right after clearly shows a causal relationship between his injury of that date and his present condition.

In addition, the credible, weighty, evidence-based and consistent testimony of the treating neurosurgeon George Cybulski, M.D. fully supports the finding of causal relationship. The Arbitrator specifically finds and concludes Dr. Cybulski's testimony outweighs the less credible and less reliable testimony of Respondent's examining expert Dr. Ghanayem.

Dr. Cybulski testified to his ongoing care and treatment of Petitioner. Dr. Cybulski testified to the objective findings on all the MRIs that he reviewed. It was Dr. Cybulski who performed the surgery and observed that the herniated disc at L4-L5 was compressing the nerve root. (Pet. Ex. No. 9, p. 23) Dr. Cybulski also opined that after being injured at work, Petitioner experienced the radicular symptoms that necessitated his surgery. (id., p. 20)

The evidence is also uncontradicted that following Petitioner's surgery that the pain and numbness to his legs were basically resolved. This indicates the surgery was both reasonable and necessary based on a medical viewpoint.

Dr. Cybulski also testified that he reviewed the surveillance video and it did not change his opinion. (Id., p. 18 and 30)

This is in contrast to Dr. Ghanayem who saw Petitioner one time and never reviewed Petitioner's operative report and has not performed any other work on Petitioner's case since June 2018. (Resp. Ex. No. 2, p. 30)

Therefore, based on a review of all medical evidence presented the Arbitrator places far greater reliance, weight and credibility on the testimony, opinions and medical records of Petitioner's treating neurosurgeon George Cybulski, M.D. over the testimony of Respondent's Section 22 examining physician Alexander Ghanayem, M.D.

Therefore, based on the evidence in record the Arbitrator finds that and concludes Petitioner has proven by a preponderance of the credible evidence that his current condition of ill-being regarding his low back is causally related to his agreed accident at work sustained on January 23, 2017.

K. In support of the Arbitrator's decision as to the amount of compensation due for temporary total disability, the Arbitrator makes the following findings and conclusions:

The Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence entitlement to temporary total disability benefits in accordance with his claim, that being temporary total from January 24, 2017 (the day after his accident) through the date of hearing on December 2, 2019 or a period of 148-4/7 weeks of TTD, or the total sum of $55,466.05 before credits, as noted herein (148-4/7 weeks x $373.33).

Respondent claims Petitioner is entitled to be paid through July 12, 2018 (a period of 72-6/7 weeks) based on what Respondent's has paid in benefits. The parties stipulated Respondent has paid temporary total disability benefits in the amount of $27,257.62. (Arb. Ex. No. 1). Respondent shall receive such credit for all amounts of TTD so paid.

It is undisputed Petitioner sustained a compensable accident on January 23, 2017. The Petitioner is found to be very credible. The medical records submitted into evidence support the fact that Petitioner ordered to remain off work during the period of TTD at issue and awarded. The evidence also indicates Petitioner remains under active medical care and has not reached maximum medical improvement.

Therefore, Petitioner is entitled to receive a total of 148-4/7 weeks of TTD benefits being the sum of $55,466.01. Since Respondent has paid $27,257.63 and shall receive credit for same, Respondent is ordered to pay the balance of $28,208.39.

J. In support of the Arbitrator decision as to whether Respondent's is liable for Petitioner's medical bills, the Arbitrator makes the following findings and conclusions

The Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence entitle to payment of all claimed unpaid medical bills as noted below. Petitioner's testimony and the medical records in evidence, including the deposition testimony of Dr. Cybulski, fully support payment of these medical bills. The parties stipulated Respondent has paid the sum of $10,432.90 in medical bills, for which Respondent shall receive credit under this award.

Petitioner entered into evidence the following bills as found in PX 1:

- Liberty Physical Therapy $16,025.00
- Dr. Ihm $989.00
- Equian $6,285.44

Since the Arbitrator determine Petitioner's current medical condition is causally related to his agreed January 23, 2017 work injury, Respondent's is found liable for the medical bills submitted under Petitioner's Exhibit Number 1 which total $23,299.44.

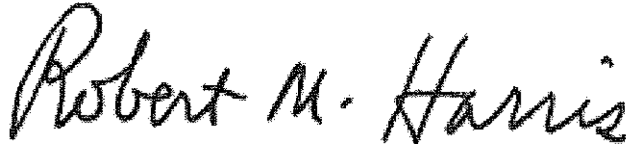
The Respondent shall pay the amounts due pursuant to the medical fee schedule pursuant to Section 8(a) and 8.2 and receive credits for any bills already paid.

Further, Equian's bill represents the bills paid by Medicaid which Respondent remains liable and Respondent will reimburse Medicaid for the amounts due.

O. In support of the Arbitrator decision as to future medical, Arbitrator makes the following findings and conclusions:

Petitioner credibly testified he remains under active medical care for the injury he suffered at work and continues to treat with Joseph Ihm, M.D. and the medical offices of George Cybulski, M.D. Dr. Cybulski's deposition testimony confirms Petitioner's testimony. Dr. Cybulski testified Petitioner will continue to require further medical treatment.

Therefore, it is ordered that Petitioner shall continue to receive reasonable and necessary medical treatment for the agreed injury he sustained on January 23, 2017.



February 3, 2020

Robert M. Harris, Arbitrator | Date