ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC014524
Case Name	LOVE, DERRICK L v. CHICAGO TRANSIT AUTHORITY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0123
Number of Pages of Decision	18
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Jennifer Kelly
Respondent Attorney	Laura Hartin

DATE FILED: 4/1/2022

/s/Maria Portela, 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

DERRICK L. LOVE,

Petitioner,

vs. NO: 16 WC 14524

CHICAGO TRANSIT AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

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

We initially note that Respondent does not dispute that Petitioner's incident occurred "in the course of" his employment. The dispute is whether it also "arose out of" his employment. The Arbitrator found that Petitioner's injuries did arise out of his employment because:

> There was no evidence that the incident that occurred on April 13, 2016 involved any personal risk for Petitioner. His risk of injury was due to the access that Respondent's garage provided to the public and the fact that Petitioner worked the overnight shift. His work task of cleaning a bus window (with his back to the accessible garage entrance and to the rushing intruder) also increased the risk of a shocking attack from behind. Petitioner's employment created an enhanced risk of criminal attack. Holthaus v. Industrial Commission of Illinois, 127 Ill. App. 3d 732 (1984). The injury arose out of Petitioner's employment by Respondent. *Dec. 7.*

Holthaus involved a swimming pool manager who was working alone at the pool at 6pm when an escaped convict shot her and attempted to steal her car. *Holthaus at 734-35*. The appellate court reversed the Commission's denial of benefits and found that Ms. Holthaus' injuries arose out of her employment because:

- The pool area "was isolated to a significant extent compared to the rest of the community at the time of year (midspring) where the assault took place."

- "The pool being closed, the public had no occasion to visit the pool area."

- "The general public was neither required to be there nor had any reason to be there and Holthaus' employment caused her to be there at various times and frequently alone." *Id. at 736*.

The court continued:

> We reject respondent's contention that Kitchell Park is a recreation area not unlike hundreds of others in Illinois regarding its setting and surroundings. While it is true that Holthaus did not prove that the Kitchell Park pool area at the time of the assault was isolated compared to other municipal parks or other pools being worked on prior to being opened to the public, **we find this to be a misleading comparison**. **Not every city employee is required to work alone in a municipal park; not everyone who is at a municipal park is required to be there, frequently alone. The appropriate requirement for compensation is that one's employment subjects him to an increased risk "beyond that to which the general public is subjected."** [Citations omitted.]
>
> Finally, it is of no consequence that the attack apparently was related to Holthaus' car and unrelated to any of respondent's property, although Holthaus was required to use her personal car as a part of her employment. **A claimant need not establish that the environment increased the risk of attack and also that the attack was motivated by something related to claimant's employment. Proof of either one or the other suffices to establish the requisite causal link.** 1 A. Larson, Workmen's Compensation sec. 11.11(b), at 3 -- 145 (1982).

Holthaus at 737-38 (Emphases added).

As the court indicated, comparing the isolation and surroundings of the pool Ms. Holthaus worked at compared to "hundreds of others in Illinois" is a misleading comparison. The question is whether her risk was increased "beyond that to which the general public is subjected." *Id*. Applying the *Holthaus* logic to the case at bar, it would seem that Petitioner *was* exposed to a risk greater than the general public based on the factors the Arbitrator identified.

On the other hand, Respondent argues that Petitioner was not exposed to an increased risk over the general public because:

- There is no expert testimony that this was a dangerous neighborhood.

- Petitioner was not isolated.

- Petitioner was working with four or five co-workers at the time.

- There is no showing that Petitioner's work generally required him to have his back to the front of the garage and Petitioner just happened to be facing the back of the garage at the moment that the intruder walked in. *R-brief at 10-11*.

Respondent argues that *Holthaus* is inapplicable because Petitioner was not alone in an isolated area and, therefore, was not exposed to the same risk as Ms. Holthaus. Respondent further attempts to frame this as a "positional risk" issue (i.e., an injury is not compensable solely because it occurred at work). In direct contradiction to Respondent's argument, however, the April 20, 2016 "Supervisor's Report of Employee Injury on Duty," signed by Martin Ward, clearly states that an "unsafe condition" existed of "no security." *Rx1 at 10*.

We generally agree with the Arbitrator's analysis but find that analyzing the increased risk related to Petitioner's work environment is unnecessary because the second option, as identified by the *Holthaus* court, is much clearer. From our viewing of the video, in conjunction with Petitioner's testimony and Respondent's reports regarding the incident (*Rx1*), it seems more likely than not that the assailant's motivation was to board the bus and Petitioner was in his way. If Petitioner had not been performing his job, the assailant would not have attacked him. In other words, there is no evidence that this assailant would have attacked Petitioner or any member of the general public that evening for any reason other than attempting to get on the bus, which was in the garage and not in service at the time. This is supported by the fact that the assailant did not attack any of Petitioner's co-workers who were also in the garage. Therefore, as the *Holthaus* court stated:

> A claimant need not establish that the environment increased the risk of attack and also that the attack was motivated by something related to claimant's employment. **Proof of either one or the other suffices to establish the requisite causal link**. 1 A. Larson, Workmen's Compensation sec. 11.11(b), at 3 -- 145 (1982). *Holthaus at 737-38.*

We find that Petitioner's "attack was motivated by something related to claimant's employment." The assailant wanted to board Respondent's bus and Petitioner, who as Respondent's employee and performing his job cleaning that bus, was in the assailant's way. Therefore, it does not matter whether Petitioner's work environment itself created an increased risk, since the attack was motivated by something related to Petitioner's employment.

Apparently in an attack on Petitioner's credibility, Respondent argues that Petitioner's injury reports and medical records contain various stories ranging from Petitioner denying that the assailant touched him, to the assailant having a knife and attempting to kill himself, to the assailant having a gun and actually killing himself. Petitioner testified that he did not recall reporting that he was physically unharmed (*T.26*) and disagreed that he told his doctor that the man had a gun and ended up killing himself. *T.36*. It is true that Petitioner's reports and medical

records do contain various versions of the event. Some describe an innocuous event and others a very traumatic one. However, they all indicate that *something* happened to Petitioner that day.

Significantly, Respondent did not call any witnesses to dispute Petitioner's testimony regarding what the intruder said or did during this event. In particular, the man in the "green-shirt" in the videos (who boarded the bus after the intruder and appeared to talk to him at length) was not called to contradict Petitioner's testimony that he believed the intruder had a knife (*T.11, 13*) and was trying to kill himself because "he had the object to his neck." *T.13, 23*.

For the foregoing reasons, we affirm the finding that Petitioner's injuries arose out of his employment but modify the rationale to reflect that his attack was motivated by something related to his employment with Respondent.

On the issue of causation, Respondent argues that this is a mental-mental case. We note that the Arbitrator's decision does not specifically find whether Petitioner was physically touched by the intruder and it is unclear whether the Arbitrator was using a physical-mental causation analysis or a mental-mental analysis. However, in the findings of fact, the Arbitrator discussed the surveillance video and wrote, "A quick (few seconds) altercation is seen at the bottom right of the view, but is not totally clear. *Dec. 3*. First, we clarify that the Arbitrator seems to have been referring to the "bottom right" portion of the video in the upper left corner of *Rx2*. We note that the altercation is also seen in the upper right video. Second, the Arbitrator's use of the word "altercation" does not necessarily connote a physical touching. The Arbitrator did mention that "Petitioner testified the man made contact with him and he was able to wrestle him off by pushing the man away" (*Dec. 3*) but the Arbitrator never made a factual finding that the intruder actually touched Petitioner.

The frame rate of the video is very low and seems to have only one or two frames per second, which results in a lot of action taking place between frames. Nevertheless, we find that the video supports Petitioner's testimony that the intruder "grabbed" him (*T.12*) but Petitioner was able to "fight him off." *T.11.* Having made that factual finding, we clarify that this is a physical-mental case and, as such, all of Respondent's mental-mental arguments are inapplicable. We also point out that even Respondent admits, "In the security footage, brief 2 second physical contact is made between Petitioner and the intruder." *R-brief at 14*. Therefore, this is not a mental-mental case.

In any event, Respondent did not obtain any medical opinion to contradict the diagnoses of Petitioner's health professionals. The April 19, 2016 Cook County Hospital return-to-work note states, Petitioner "has been referred by PCP for workers' compensation from employer." On April 28, 2016, Dr. Lakhani diagnosed "Stress/anxiety… [due to] incident at work." On June 3, 2016, Katy Howe, LCSW wrote that Petitioner was experiencing "symptoms related to Acute Stress Disorder as a result of a recent traumatic event that he experienced at work."

We therefore affirm the Arbitrator's finding that Petitioner's conditions were causally related to his accident but clarify that this is a physical-mental case.

All else is affirmed and adopted.

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

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

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

Pursuant to §19(f)(2) of the Act, Respondent is not required to file an appeal bond in this case. 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 1, 2022

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

SE/
O: 2/15/22
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0123

LOVE, DERRICK L
Employee/Petitioner

Case# **16WC014524**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

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

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

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

0009 ANESI OZMON RODIN NOVAK KOHEN
HAYLEY GRAHAM SLEFO
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
LAURA HARTIN
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

D. Love v. CTA, 16 WC 014524

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

DERRICK L. LOVE
Employee/Petitioner
v.
CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # **16** WC **014524**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **July 11, 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 _____

D. Love v. CTA, 16 WC 014524

FINDINGS

On **April 13, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,800.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **40** years of age, ***married***, with **1** dependent child, per the stipulation of the Parties.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 21 weeks, commencing 4/18/16 through 9/12/16, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week 10 for weeks, because the injuries sustained caused the 2% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services in the amount of $493.78, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner all awarded compensation benefits that have accrued from 4/13/2016 to 7/11/2019 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

October 11, 2019
Date

OCT 16 2019

FINDINGS OF FACT

Petitioner, Derrick Love, was employed by Respondent, Chicago Transit Authority, as a bus servicer. He worked at Respondent's garage located at Kedzie and Jackson. Petitioner worked the overnight shift from 8 p.m. to 4:30 a.m. He was in a two-year apprenticeship program.

Petitioner testified that while he was working on April 13, 2016, an unknown man entered the garage through an open garage door, charged at him and attacked him. Petitioner was cleaning the windows on the outside of the front of a bus and had his back to the man as he approached. Petitioner testified he noticed the man charging at him from over his shoulder when he was about 10 feet away. Petitioner testified he saw a silver sharp object in the man's hand. Petitioner testified the man made contact with him and he was able to wrestle him off by pushing the man away. This happened quickly, in a matter of seconds.

Petitioner testified that he was scared, nervous and feared for his life during the encounter. Petitioner testified he thought the silver sharp object in the man's hand was a knife. Petitioner testified, "Everything happened so fast." Petitioner testified the man then got onto the bus, where he stood holding the sharp metal object to his neck. Petitioner testified he thought the man was going to try to kill himself. Petitioner testified that he then sat because he was "shook up" and "couldn't do any more work."

CTA surveillance video shows a man entering the garage from an opened door and quickly approaching Petitioner from behind as he stood in front of a bus. (RX 2) The view is from the camera inside of the bus. A quick (few seconds) altercation is seen at the bottom right of the view, but is not totally clear. The man is then seen entering and standing on the bus with a silver object in his hand that he is holding at his neck. The object is not identifiable in the video.

Petitioner testified that following the incident he could not sleep or eat, he was nervous and was off. Petitioner filled out a Report to Manager on April 14, 2016. (RX 1) He summarized the incident as follows:

> "4-13-16 I Derrick Love, was attack by someone that came in the garage I was standing in front of my assigned bus #4200 when I look back and seen someone approaching me real fast

when he got close enough for me to push him off I did then he entered my bus with a object in his hand holding it to his neck yelling out words. I walked off and told manager. Later that night I got severe headaches, arm pain and body pain." (RX 1)

Petitioner testified that he had severe headaches and went to the emergency room at West Suburban Medical Center on April 15, 2016 due to these symptoms. Petitioner gave a history of being nearly attacked by a man who then held a knife to his neck threatening to kill himself at work. (PX 1) He described the situation stressful and reported the headache starting two hours after and had been persistent. He reported feeling jittery and having nightmares. Petitioner was diagnosed with tension headaches and hypertension. He was prescribed Lopressor and was told to follow up with his primary doctor. (PX 1)

On April 18, 2016, Petitioner presented to his PCP, Dr. Ashok Lakhani of Oak Park Medical Center, and the history was something terrible happened at work and someone with a gun tried to injure patient and instead the person ended up killing himself in a bus that he was cleaning. Petitioner reported being really shaken, anxious, worried, unable to sit still and unable to work. Dr. Lakhani referred him for psychological evaluation and restricted him from working, effective April 15, 2016. (PX 2)

Petitioner testified that he filled out an Employee's Report of Injury on Duty on April 20, 2016. (RX 1) On the report at number 21 where it asks, "What were you doing before the injury occurred?" he wrote, "I was cleaning a CTA bus when a intruder/trespassor attack me." At number 20 on the report where it asks what type of injury, he wrote "mental, severe headaches." Petitioner summarized the facts of the incident on the report as follows:

"I Derrick Love was cleaning a CTA bus when an intruder off the street ran into the garage and attacked with an object in his hand I was able to get him off me then he jump on the bus I was cleaning and put object to his neck as in trying to kill himself." (RX 1)

Also, on April 20, 2016, Petitioner filled out a First Aid Log where he described his injury as "severe headache do to anxiety" caused by being "attacked by a trespasser/intruder." (RX 1)

Petitioner testified he presented for a psychiatric evaluation on May 31, 2016 at the Ruth M. Rothstein Core Center. (PX 3) The history was that he "was attacked at work recently by a man with a knife (6 weeks ago) and has been struggling emotionally/mentally since then and unable to work." The history was that an intruder ran into the garage where he was working on a CTA bus and the man attacked him with a knife but he was able to wrestle him to the ground and get away. The history further states he witnessed the man run on the bus and attempt to cut his own throat. Petitioner noted no prior history of psychiatric episodes or treatment. He reported paranoia and anxiety since the event, as well as having flashbacks and being unable to sleep. Petitioner was diagnosed with acute stress disorder. He was referred for further psychiatric consultation and restricted from working. (PX 3)

On July 21, 2016, Petitioner presented to the Core Center for psychiatric treatment. The history was of an incident at work while cleaning a bus three months ago where a person with a sharp object or knife in his hand tried to put that object into his neck and yelling something. Petitioner reported flashbacks and nightmares almost daily. He reported being hypervigilant, paranoid, feeling depressed and anhedonic since the incident. He reported feeling helpless and worthless, having trouble with concentration, low energy and no appetite. He reported a 5-6 pound weight loss. Petitioner was diagnosed with PTSD and major depression. He was prescribed Remeron and advised to follow up for psychiatric care. (PX 3)

Petitioner followed up for psychiatric treatment on August 2, 2016 and August 30, 2016. (PX. 3). He continued to report feeling paranoid, fatigue, and that he could not sleep or eat. The flashbacks and nightmares persisted. (PX 3)

Petitioner testified was released back to work on September 12, 2016. He returned to the same position at CTA, working the same overnight shift. Petitioner testified he felt jumpy and nervous at work.

On September 15, 2016, Petitioner returned to Core and reported feeling better, but still reporting symptoms of anxiousness, jittery, shaky, nauseated, sweaty and heart palpitations daily. He reported low energy levels and feeling depressed. (PX 3)

On October 18, 2016, Petitioner returned to Core and reported still feeing anxious, depressed and helpless. He still noted flashbacks and nightmares three to four times a week. His medication was continued. (PX 3)

Petitioner again had a follow-up visit on January 27, 2017. He advised that he was non-compliant with medication for the past couple of weeks because he was feeling better and wanted to "try without medication." He lost his job about a month ago because he was not getting along with his supervisor. He was placed back on nights at the same location and he was unhappy because it made him more anxious. He is looking for a new job. He feels less depressed and hopeless. He still gets anxious when he is around a lot of people. Having flashbacks around 1-2X per week. Much less than before. He wants to feel less depressed and anxious. (PX 3)

Petitioner's final date of treatment was April 4, 2017. He had been off medication for 2 months. He noted he was feeling much better and PTSD symptoms were not noted. He was discharged from care and his medication was discontinued. The Discharge Diagnosis was Major Depressive Disorder-recurrent episode, moderate. A return to clinic date of May 16, 2017 was given. Apparently, there was no follow-up care. (PX 3)

Petitioner testified that today he is doing much better. He is no longer having flashbacks and is not experiencing the symptoms he had following the incident. Petitioner testified he is not undergoing treatment and does not need to take medications. Petitioner testified the psychiatric care helped improve his symptoms. He is no longer employed at the CTA. Petitioner testified he is working now at Rock of Ages Baptist Church.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980), including that there is some causal relationship between his employment and the injury. Caterpillar Tractor Co.

v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Petitioner must show "...that he has suffered a disabling injury which arose out of and in the course of his employment." Sisbro, Inc. v Industrial Comm'n, 207 Ill.2d 193, 203 (2003)

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)

REGARDING ISSUE (C), WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT, THE ARBITRATOR FINDS:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 13, 2016. that arose out of and in the course of his employment with Respondent.

The event obviously occurred in the course of Petitioner's employment. He was on Respondent's premises, cleaning the windshield on one of Respondent's buses (one of his employment duties), during his work hours. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 57 (1989)

There was no evidence that the incident that occurred on April 13, 2016 involved any personal risk for Petitioner. His risk of injury was due to the access that Respondent's garage provided to the public and the fact that Petitioner worked the overnight shift. His work task of cleaning a bus window (with his back to the accessible garage entrance and to the rushing intruder) also increased the risk of a shocking attack from behind. Petitioner's employment created an enhanced risk of criminal attack. Holthaus v. Industrial Commission of Illinois, 127 Ill.App.3d 732 (1984) The injury arose out of Petitioner's employment by Respondent.

REGARDING ISSUE (F), WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

Having found a compensable accident did occur, the Arbitrator further determines that Petitioner's current condition of ill-being (resolved PTSD, Major Depressive Disorder-recurrent episode, last treatment in April of 2017) is causally related to the work accident of April 13, 2016. The Arbitrator places significant

weight on the credible testimony of Petitioner and the contemporaneous medical records. Petitioner's testimony regarding his symptoms following the injury was consistent with the treating records. Petitioner's testimony regarding his medical condition and his treating physician's opinions went unrebutted at hearing. The evidence in the medical records points to no prior history of psychiatric care. The medical records also support a finding that the PTSD, depression and headaches conditions were caused by the events of April 13, 2016.

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

The medical services that were rendered to Petitioner were reasonable and necessary to cure or relieve the effects of the injuries sustained. This finding is based on Petitioner's testimony and the medical records, along with the Arbitrator's finding on ISSUE F, Causation, above. Petitioner's Bills Exhibit was PX 4. Petitioner claimed that Respondent was liable for the payment of 3 medical bills: Cook County Hospital, $1,540.00; West Suburban Hospital, $493.78; and EMPG of Illinois, $177.80. (ArbX 1)

The bill from Cook County Hospital is denied. It is for outpatient and lab services on April 19, 2016. There was no testimony regarding this treatment and no supporting medical records were submitted into evidence.

There was no bill submitted from EMPG of Illinois and the same is denied. A bill from Pendrick Capital Partners was included in PX 4, but there is no date of service, no description of the services and no explanation of any relationship between Pendrick and EMPG.

The bill from West Suburban Hospital in the amount of $493.78 is awarded, pursuant to the Illinois Workers' Compensation Commission Fee Schedule and Section 8.2 of the Act.

REGARDING ISSUE (K), WHETHER PETITIONER IS ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS, THE ARBITRATOR FINDS:

The Arbitrator finds that Petitioner is entitled to temporary totally disability benefits from April 18, 2016 through September 12, 2016. Dr. Lakhani first saw Petitioner on April 18, 2016 and restricted Petitioner from work, effective April 15, 2016. Of course, to be entitled to TTD benefits, a claimant must prove not only that he did not work, but that he was unable to work. Cropmate Co. v. Industrial Comm'n, 313 Ill. App. 3d 290, 296 (2000) TTD is not awarded absent a medical excuse authorizing the claimant off work. The Arbitrator is not persuaded by an Ex Post Facto off work excuse. Dr. Lakhani endorsed off work status until Petitioner had a psych consult. Petitioner was excused from work by Core (psych treatment) from May 31, 2016 through September 12, 2016. Respondent submitted no evidence rebutting Petitioner's testimony and the medical records. **Accordingly, Respondent is to pay 21 weeks of temporary total disability benefits.**

REGARDING ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

An AMA impairment rating was not obtained in this matter; however, Section 8.1(b) of the Act requires the Commission's consideration of five factors in determining permanent partial disability:

1. The reported level of impairment;
2. Petitioner's occupation;
3. Petitioner's age at the time of the injury;
4. Petitioner's future earning capacity; and
5. Petitioner's evidence of disability corroborated by treating medical records.

Section 8.1(b) also states, "No single 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 a physician must be explained in a written order." The term "impairment" in relation to the AMA

Guides to the Evaluation of Permanent Impairment 6th Edition is not synonymous with the term "disability" as it relates to the ultimate permanent partial disability award.

1. The reported level of impairment

An AMA impairment rating was not done in this case. This does not preclude an award for permanent partial disability. This factor is given no weight in determining PPD.

2. Petitioner's Occupation

On the date of the accident, Petitioner was a bus servicer. He was able to return to work in this position without restrictions. This factor is given great weight in determining PPD.

3. Petitioner's age at the time of injury

Petitioner was 40 years old at the time of injury, and he is 43 years old at the time of the hearing. His age is not a factor in determining PPD for the injuries suffered. This factor is given no weight in determining PPD.

4. Petitioner's future earning capacity

Petitioner has no loss of earning capacity as a result of the injury. Nothing in the Record, including his testimony, suggests that his future earning capacity has been affected by the injuries sustained. Great weight is placed on this factor in determining PPD.

5. Petitioner's evidence of disability corroborated by medical records

As a result of the work injury, Petitioner suffered from PTSD, depression, and headaches following the event. He underwent psychological treatment, including being prescribed an antidepressant for approximately one year following his injury. Petitioner testified he had difficulty returning to the same shift at work and experienced anxiety while working. Petitioner testified that the treatment he underwent helped significantly and that he was doing "much better." This factor is given appropriate weight in determining PPD.

After considering the above factors and the Record as a whole, the Arbitrator finds that the injuries sustained caused Petitioner to suffer the 2% loss of use of a person as a whole, in accordance with Section 8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC024206
Case Name	GORDON, MARTY v. KRAFT HEINZ
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0124
Number of Pages of Decision	18
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Matthew Kelly
Respondent Attorney	James Clune

DATE FILED: 4/5/2022

/s/ Deborah Baker, Commissioner

Signature

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

MARTY GORDON,

Petitioner,

vs. NO: 20 WC 24206

KRAFT HEINZ,

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 whether Petitioner sustained an accidental injury arising out of and occurring in the course of his employment on July 7, 2020, whether his current condition of ill-being is causally related to the accident, entitlement to incurred medical expenses, entitlement to prospective medical care, and whether benefit rates and wage calculations are accurate, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2021 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay reasonable and necessary prospective medical care recommended by Dr. DeGrange, including, nut not limited to, a posterior cervical dicectomy and fusion at C4-5 as provided in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

April 5, 2022

/s/ *Deborah J. Baker*

DJB/lyc

O: 3/30/22

/s/ *Stephen J. Mathis*

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/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC024206
Case Name	GORDON, MARTY v. KRAFT HEINZ
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	15
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Matthew Kelly
Respondent Attorney	James Clune

DATE FILED: 7/16/2021

THE INTEREST RATE FOR THE WEEK OF JULY 13, 2021 0.05%

/s/ Linda Cantrell, Arbitrator

Signature

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)

Marty Gordon
Employee/Petitioner

v.

Kraft Heinz
Employer/Respondent

Case # **20** WC **24206**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **4/13/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/7/2020**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**56,170.40**; the average weekly wage was $**1,080.20**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Respondent ***has or agrees to pay*** 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** in other benefits, for a total credit of $**0.**

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

ORDER

Respondent shall pay reasonable and necessary prospective medical care recommended by Dr. DeGrange, including, but not limited to, a posterior cervical discectomy and fusion at C4-5.

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.

_____ **JULY 16, 2021**

Signature of Arbitrator

ICArbDec19(b)

STATE OF ILLINOIS)
) **SS**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARTY GORDON,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case. No. 20-WC-024206
	)	
KRAFT HEINZ,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACTS

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on April 13, 2021 pursuant to Section 19(b) of the Act. The parties stipulate that the issues in dispute relate solely to Petitioner's cervical spine and not his left shoulder injury. The issues in dispute are accident, causal connection, average weekly wage, and prospective medical care.

TESTIMONY

Petitioner was 50 years old, married, with no dependent children at the time of the alleged accident. Petitioner was employed by Respondent for seventeen years and held the position of pouch machine operator for two years. Petitioner testified the machine he operates makes pouches for Capri Sun drinks. He stands by an automated conveyer line of empty boxes, removes a box from the conveyor belt, places the box into the pouch machine to be filled with empty pouches, inspects the pouches, labels the box, and places the box back on the conveyor belt where he pushes it down the line to the filler room. The filler operators empty the boxes and place them back on the conveyor belt to be returned to Petitioner's department.

At arbitration, Petitioner drew a diagram of his workstation that was marked Petitioner's Exhibit 11 and admitted into evidence without objection. He stated the boxes on the conveyor belt are at head/eye level requiring him to reach up to grab the boxes. Petitioner testified he typically reached up and grabbed the boxes with his left arm as the left side of his body was toward the conveyor belt. Petitioner then turns around and places the empty box in one of two pouch machines to be filled. Once the box is filled, he inspects the pouches, tapes the box closed, labels the box, and places it back on the conveyor belt. Petitioner operated two pouch machines at the same time and his quota

was one box every five minutes per machine. He worked eight hours shifts and four hours overtime when required. He testified he often worked overtime and worked at least four hours per week overtime. It is his understanding he could not refuse overtime or he would be given a half point and ultimately be terminated for accumulating too many points.

Petitioner testified the conveyor belt is automated and 70 feet long. He stated the belt often malfunctioned and they had to pull boxes down the belt to their machines. Approximately 60 to 70 boxes were physically pulled down the conveyor belt at a time while the belt was moving in the opposite direction. Petitioner testified he and his co-workers pulled the boxes down the conveyor approximately 30 to 40 feet. Petitioner placed a fiberglass stick on the conveyor belt to keep the boxes stationed in front of the pouch machines while to conveyor belt continued to move. He testified that keeping the boxes stationary caused pressure on the boxes making it difficult to pull the boxes off the conveyor. He testified he frequently assisted his co-workers with their pouch machines resulting in handling more than two boxes per five minutes. He stated that sometimes the boxes were double stacked, or a box inside of a box, causing more pressure on the boxes and making it more difficult to remove them from the conveyor. If the boxes were doubled up he would have to reach above head level to grab them.

Petitioner identified himself in a video marked Respondent's Exhibit 7. The video depicts him reaching up to grab a box off the conveyor with his right arm. He testified the video was taken after his injury and reaching up with his left arm caused soreness and aggravated his symptoms. He testified the conveyor belt was running properly in the video.

Petitioner testified that on Monday, 7/6/20, he worked a 12-hour shift. Every Monday is a startup day where they start up the machines and the boxes typically run slower on the conveyor belt and they run out of boxes. When he returned to work on Tuesday he stated to his co-worker his shoulder was sore and tight when he grabbed boxes off the conveyor. He worked his regular shift on 7/7/20 and stated he felt the symptoms in the side of his neck. He worked the rest of the week and felt aching symptoms in the evenings while resting. He worked a 12-hour shift on Friday and that evening he applied ice and took Ibuprofen due to pain in his left shoulder and neck. He testified that over the weekend he had to put his left arm up behind his head with his hand down to the right side of his head to get relief. He reported his injury to his supervisor the following Monday, 7/13/20, and completed an accident report that day.

Respondent's Safety Manger, Jim Styler, drove Petitioner to Occupational Medicine where he reported symptoms in his left shoulder and neck. He reported prior shoulder surgeries in 2001. Petitioner testified he did not have any restrictions for his left shoulder and did not miss any work due to his left shoulder since working for Respondent. Petitioner testified he had a work-related elbow injury in 2007 while working for Respondent and underwent surgery. He did not miss any work from 2004 through July 2020 for issues related to his neck.

Occupational Medicine ordered a cervical and left shoulder MRI, referred Petitioner to Dr. Rotman for his shoulder and Dr. DeGrange for his neck, and placed him on work restrictions. He saw Dr. Rotman twice and provided him with a history of injury and job duties. Petitioner provided Dr. DeGrange a history of injury and physical therapy was ordered which he underwent from 9/14/20 through 12/11/20. Dr. DeGrange has recommended a cervical fusion and has him on work restrictions. Petitioner testified he has been on work restrictions since 7/13/20 which Respondent has accommodated.

Petitioner was examined by Dr. Mirkin for his cervical spine and Dr. Kutnik for his left shoulder pursuant to Section 12 of the Act. Petitioner stated his exam with Dr. Mirkin lasted ten minutes. Petitioner stated he provided Dr. Mirkin with an accurate description of his job duties. Petitioner testified his cervical surgery was initially approved and he underwent pre-operative workup. He stated he also provided Dr. Kutnik with an accurate description of his job duties and history of injury.

Petitioner testified he currently has numbness and soreness in his shoulder that radiates down the underside of his arm. He has a cold, numbing sensation across his chest into the side and back of his neck that causes headaches. His symptoms are constant and the severity increases with activity. He testified he was not engaged in any activity outside of work in July 2020 that caused or aggravated his neck or left shoulder conditions. He desires to undergo the surgery recommended by Dr. DeGrange.

On cross-examination, Petitioner testified he had a work-related right elbow injury years ago and received approximately $35,000 from that workers' compensation settlement. He had a work-related injury in 2001 while performing landscaping for another employer which was settled based on a reduced earnings capacity. Petitioner testified he underwent a left and right shoulder debridement and it was recommended he not return to tree trimming work with no specific restrictions.

He testified he is six foot tall. The boxes are on rollers on the conveyor belt and are located at his head level. He agreed that overtime is initially voluntary and if enough employees do not volunteer overtime is assigned based on seniority status. If an employee refuses overtime he received a half point. He is the lowest in seniority on day shift and has refused overtime a few times. He testified he takes a 30-minute lunch break and two 15-minute breaks per shift.

Respondent called Robbie Robertson to testify. Mr. Robertson has worked for Respondent for nineteen years and is the Safety Coordinator. He assists the Safety Manager and monitors and writes the safety programs. He testified that the videotapes entered into evidence accurately reflect the job duties of a pouch operator. He has assessed the movements and functions of the pouch operator position for safety purposes. He has performed various positions, including filler and packing operator, during his employment with Respondent.

Mr. Robertson testified that overtime is voluntary unless there is a shortage of volunteers in which case overtime is assigned in rotation starting with the lowest senior

employee. Each employee within a department takes their turn in rotation. If an employee refuses overtime he receives an attendance point. A written warning is issued after three points within a 12-month period. A total of nine points are allowed in a 12-month period before an employee is terminated.

Mr. Robertson identified himself in the second video marked Respondent's Exhibit 7. He testified he is 5'10" tall and he is shown removing an empty box from the conveyor belt at the pouch operator machine. He testified the boxes are on metal rollers and not much pressure is required to remove a box from the conveyor belt. He testified the belt breaks down a couple of times per week. When the belt breaks down a pallet of boxes are brought to the pouch operator room and the operators place the boxes on the belt. He testified that the conveyor belt depicted in the video is 61 inches from the ground.

On cross-examination, Mr. Robertson testified he is depicted in the video pushing approximately 6 to 7 boxes back when he removed a box from the conveyor. He testified that while he videotaped Petitioner performing his job duties Petitioner told him there were issues with the conveying system and pressure on the boxes. He agreed you have to hold boxes back while removing a box from the conveyor but he would not say the task was "difficult". He testified that a full point is given if an employee refuses overtime, not a half point.

MEDICAL HISTORY

On 7/13/20, Petitioner was taken to Gateway Regional Occupational Health by Respondent. Petitioner complained of shoulder pain that developed on 7/6/20 while performing his regular job duties of pulling boxes off a conveyor belt. Petitioner reported he was required to perform repetitive activities and at times he was forced to dislodge boxes. He reported a sudden onset of pain that progressed over time and he applied ice and Ibuprofen that did not resolve his pain. He reported constant dull pain of 5 out of 10 and stiffness in his left shoulder that radiated to his elbow. He reported the only relief of his symptoms was to elevate his arm over his shoulder and turn his head. Petitioner disclosed his prior shoulder surgeries 20 years ago and a right elbow surgery.

Physical examination revealed tenderness over the posterior scapula with full range of motion and strength. X-rays of the cervical spine and left shoulder were unremarkable. He was diagnosed with a cervical strain with radiation to his left shoulder. He was ordered to return to restricted work of no lifting over 10 pounds, no bending, twisting, or stooping, and no lifting over the shoulder. He was instructed to continue taking Tylenol and alternate cool and moist heat.

On 7/15/20, Petitioner returned to Gateway Regional and noted an improvement in his symptoms with home exercises. He noted increased pain into his left shoulder with resisted neck extension and driving. His work restrictions and treatment protocol were continued. Petitioner's symptoms failed to improve and MRIs of his left shoulder and cervical spine were performed on 8/14/20. Petitioner was referred to Dr. Donald

DeGrange to assess his cervical condition and Dr. Mitchell Rotman for his left shoulder condition. His work restrictions were continued pending consultation.

On 8/27/20, Petitioner was examined by Dr. Rotman and provided a history of pulling boxes off a conveyor line on 7/6/20 when he noted left shoulder pain with slight improvement since the accident. Petitioner reported prior bilateral clavicle resections and bilateral shoulder debridement surgeries in 2001. Petitioner complained of stiffness, pain with overhead use, night pain, weakness, and difficulty sleeping on the left side. He also reported neck pain, numbness, and tingling. Petitioner filled out a pain diagram showing pain in his left shoulder up to his poster shoulder blade and occasionally up to his neck. Dr. Rotman noted Petitioner pulls boxes and places them in a machine, puts a bag in the box, checks the pouches for imperfections, tape and labels each box, and pushes the boxes down the line.

Dr. Rotman's physical examined revealed "no pain whatsoever with cervical rotation and excellent shoulder motion". He noted some posterior joint discomfort that he felt might be related to the superior labral lesion shown on the left shoulder MRI. Dr. Rotman recommended Petitioner return to full duty work to determine the source of his pain as his physical exam was unremarkable.

On 9/9/20, Petitioner was examined by Dr. DeGrange at which time he advised he had an onset of neck and left shoulder pain on 7/6/20 while pulling boxes out of a tightly packed assembly line. Dr. DeGrange noted Petitioner's treatment with Dr. Rotman and Petitioner advised Dr. Rotman thought his symptoms were likely from his cervical spine and not his shoulder. Dr. DeGrange stated Petitioner denied any prior issues regarding his left shoulder or cervical spine and had no significant injury, trauma, or surgeries to either the neck or shoulder. However, the past medical history notes Petitioner underwent a right shoulder scope and elbow surgery. Petitioner complained of neck pain with radiation into the left shoulder and axillary area as well as the proximal brachium with increasing numbness and burning. He reported numbness into his left arm and hand. He reported his pain increased when elevating his left shoulder above shoulder level. Physical examination revealed a "very stiff neck" but no torticollis, significant tenderness along the spine and medial border of the left scapula, positive Foramen compression test and Spurling maneuver on the left and negative on the right. He had decreased range of motion in the cervical spine, and significant decreased left lateral bending and rotation. Dr. DeGrange found noticeable weakness to the left elbow flexion as well as internal and external rotation of the left shoulder, with no sensory deficits.

Dr. DeGrange reviewed the cervical MRI dated 8/14/20 and noted mild degenerative changes at C3-4 with foraminal compromise at both levels, a 3 mm broad-based disc bulge at C4-5 with moderate stenosis of the left foramen, and a mild, 1 mm broad-based disc bulge at C5-6 with no facet arthropathy or hypertrophy. Dr. DeGrange diagnosed a herniated disc at C4-5 with left foraminal stenosis. Dr. DeGrange opined that Petitioner's mechanism of injury appears to have caused a preexisting degenerative condition to become quite symptomatic as of 7/6/20. He opined Petitioner's subjective complaints were consistent with his physical examination findings and objective MRI

findings. He found Petitioner to be credible and gave good effort on physical examination.

Dr. DeGrange recommended physical therapy for four weeks and to take Ibuprofen and Tylenol as-needed. Dr. DeGrange ordered Petitioner to return to work with a 10-pound lifting limit and no repetitive bending and twisting of the neck. If his symptoms did not improve Dr. DeGrange recommended a C4-5 epidural steroid injection.

Petitioner received physical therapy at Gateway Regional Hospital from 9/14/20 through 12/11/20. The initial therapy note reflected Petitioner had an onset of pain in his left shoulder while pulling boxes off an assembly line. Petitioner advised he had attempted to work for a week following the onset of his symptoms, but his pain progressed.

On 9/24/20, Dr. Rotman discharged Petitioner at MMI with regard to his left shoulder and noted Dr. DeGrange has found pathology in his neck which would explain Petitioner's complaints and lateral forearm burning and pain up to his neck.

Petitioner returned to Dr. DeGrange on 10/7/20 and reported improved range of motion but "annoying" pain in his left shoulder area. Dr. DeGrange noted Petitioner still had positive Spurling maneuver and foramen compression on the left, with weakness of resisted rotation and forward flexion of the left shoulder. Dr. DeGrange noted the C4-5 imaging clearly shows the disc bulge in the foramen with significant narrowing. Dr. DeGrange ordered him to continue therapy and return in four weeks. He increased his work restrictions to a 15-pound lifting limit.

On 11/11/20, Dr. DeGrange noted Petitioner's pain had subsided to moderate with constant fatigue and soreness. He noted weakness in Petitioner's left arm, with occasional numbness/tingling over the left deltoid along the medial border of the scapula. Petitioner requested one more month of therapy to avoid a recommended posterior cervical discectomy and fusion at C4-5. Dr. DeGrange continued his work restrictions.

Petitioner was examined by Dr. Shawn Kutnik on 11/16/20 pursuant to Section 12 of the Act. Petitioner advised Dr. Kutnik he developed left shoulder and neck pain associated with his work activities in July 2020 that progressed throughout the work week. Petitioner reported working full-time for Respondent for 17 years and his job duties require him to reach up and retrieve boxes off an assembly line at shoulder height. He described the boxes are under pressure and require some force to extricate them from the line. This is the task he was performing when his symptoms developed. Petitioner reported his bilateral debridements with clavicle resections in 2001 and stated he recovered well from the surgeries. Dr. Kutnik recorded Petitioner's symptoms as mild in intensity and burning, dull, and aching in quality. He reviewed Petitioner's treating records and physical examination revealed tenderness along the left paraspinal region and trapezius and scapulothoracic region, with no real pain in the shoulder. No impingement

or instability was noted in the shoulder. Pain was noted with left lateral rotation and extension of the neck that radiated down the shoulder.

Dr. Kutnik reviewed Petitioner's job description provided by Respondent and noted the relevant qualifications state ability to lift 25 pounds with no other specifications of physical demands or frequencies provided. Dr. Kutnik opined that Petitioner's description, physical examination, and MRI findings were consistent with cervical etiology. He deferred causation of the cervical spine to Dr. DeGrange and opined Petitioner's symptoms were unrelated to a shoulder injury. He further opined that treatment and testing to date was reasonable and appropriate for workup of referred pain to the shoulder. He opined Petitioner was at MMI with regard to his left shoulder.

On 11/20/20, Petitioner was examined by Dr. Mirkin pursuant to Section 12 of the Act for his left shoulder and cervical conditions. Dr. Mirkin reported Petitioner did not know a specific incident but feels that reaching overhead to get boxes off a line caused him to have pain in the back of his neck, numbness in his left arm, and pain in his shoulder. Dr. Mirkin's physical examination revealed limited range of motion in the cervical spine, mild positive Spurling sign, and full range of motion of the left shoulder with no crepitus or supraspinatus sign. Dr. Mirkin opined Petitioner's pain was emanating from his neck. He diagnosed an asymptomatic labral lesion of the left shoulder and cervical spondylosis. Dr. Mirkin opined it is certainly possible that reaching overhead on a line could have contributed to his current symptomatology and the work-accident aggravated his pre-existing condition. He opined that all treatment has been appropriate and recommended an injection prior to surgical intervention which he felt a cervical decompression was more appropriate. He recommended a myelogram before proceeding with surgery. Dr. Mirkin stated Petitioner could return to work without restrictions.

On 1/12/21, Dr. DeGrange noted Petitioner continued to have symptoms with all activity beyond his restrictions. Petitioner advised he wanted to undergo the recommended surgery and it was scheduled on 2/15/21 pending approval. His work restrictions were continued.

On 1/13/21, Respondent requested a Utilization Review that recommended certification for an anterior cervical discectomy and fusion at C4-5. The UR did not certify the request for a cervical collar or bone growth stimulator. On 1/20/21, Dr. DeGrange's office emailed the workers' compensation adjuster and advised they received the approval for the surgery but questioned why the cervical collar and bone growth stimulator were denied. It was explained that if Petitioner's Vitamin D level was deficient, he would require the stimulator. The workers' compensation adjuster replied he would override the utilization review denial and authorize the cervical collar.

On 1/28/21, Dr. Mirkin authored a letter stating he reviewed extensive documentation, including a cover letter dated 1/25/21 from Respondent, a video, and Dr. Kutnik's report. Dr. Mirkin stated he did not see any significant reaching overhead in the video and the activities depicted in the video would not aggravate (a permanent change in the pre-existing condition) Petitioner's cervical condition. His opinion was based on the

"definitions" provided by Respondent and the video. He stated the letter he received from Respondent on 11/11/20 indicated that Petitioner alleges injuries due to overhead lifting of empty boxes which he did not appreciate on the video. He was under the impression based on the history provided by Petitioner and the first letter he received from Respondent that Petitioner's job duties required extensive overhead lifting.

On 2/3/21, Petitioner underwent pre-operative testing at Mercy Medical Tower St. Louis in preparation for surgery. On 2/17/21, the workers' compensation carrier advised Dr. DeGrange's office that after further investigation Petitioner's claim was denied and the approval for surgery was withdrawn effective immediately.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 117 Ill.2d 38, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work or that he or she is exposed to the risk of injury to a greater degree than the general public. *Id*. "In the course of employment" refers to the time, place, and circumstances surrounding the injury. *Lee v. Industrial Comm'n*, 167 Ill. 2d 77, 656 N.E.2d 1084 (1995); *Scheffler Greenhouses, Inc. v. Indus. Comm'n*, 66 Ill. 2d 361, 362 N.E.2d 325 (1977). That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 671 (2003).

Petitioner's injury clearly falls within the definition of an accident within the meaning of the Act. He was performing a task distinctly related to his employment which required him to reach at or above shoulder level to remove boxes from a conveyor belt. He experienced left shoulder and neck pain when performing this activity. He reported his injury to Respondent and provided a consistent history to his treating physicians. Petitioner's testimony was consistent with the accident report and medical records.

Based on the credible testimony of Petitioner and treating records, the Arbitrator finds Petitioner sustained his burden of proof in establishing he suffered an accident that arose out of and in the course of his employment with Respondent on July 7, 2020.

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

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury.

Gano Electric Contracting v. Indus. Comm'n, 260 Ill.App.3d 92, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). A chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident is sufficient to satisfy the claimant's burden. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982).

The record is clear that Petitioner was working full duty without incident prior to July 7, 2020. Petitioner credibly testified that after his shift on 7/6/20 he experienced pain in his neck and left shoulder. There is no evidence that Petitioner sustained injury or sought treatment for his cervical spine prior to 7/7/20. The only reasonable explanation for Petitioner's current condition of ill-being in his cervical spine is the work accident on 7/7/20.

The Arbitrator also notes that the Commission has acknowledged that there is overlap between shoulder injuries and cervical spine conditions. *See Tiffany Molton v. Red Bud Reg'l Care*, 18 I.W.C.C. 0381. Petitioner reported symptoms in his neck and left shoulder. Dr. Rotman did not believe Petitioner's symptoms were related to his left shoulder and noted Dr. DeGrange found pathology in his neck which he felt would explain Petitioner's complaints and lateral forearm burning and neck pain. Dr. DeGrange reviewed the cervical MRI dated 8/14/20 and noted degenerative changes, most predominantly a herniated disc at C4-5 with left foraminal stenosis. Dr. DeGrange opined that Petitioner's mechanism of injury appears to have caused a preexisting degenerative condition to become quite symptomatic as of 7/6/20. He opined Petitioner's subjective complaints were consistent with his physical examination findings and objective MRI findings. He found Petitioner to be credible and gave good effort on physical examination.

Petitioner underwent physical therapy, medication, and work restrictions that did not alleviate his symptoms. Dr. DeGrange ultimately recommended surgery that was scheduled on 2/15/21 pending approval. Dr. Kutnik evaluated Petitioner's left shoulder and reviewed Petitioner's job description provided by Respondent. He noted that the relevant qualifications state ability to lift 25 pounds with no other specifications of physical demands or frequencies provided. He deferred causation of the cervical spine to Dr. DeGrange.

Dr. Mirkin initially opined it is certainly possible that reaching overhead on a line could have contributed to Petitioner's current symptomatology and the work-accident aggravated his pre-existing condition. He opined that all treatment has been appropriate and recommended an injection and myleogram prior to surgical intervention, which he believed a decompression procedure was appropriate. Despite Respondent's Section 12 examiner Dr. Mirkin's opinion, Respondent's Utilization review recommended certification for an anterior cervical discectomy and fusion at C4-5. The worker's compensation adjuster overrode the UR's denial of the cervical collar. Dr. DeGrange's

office received authorization to proceed with the recommended surgery. Petitioner underwent post-operative workup.

Surgical authorization was rescinded on 1/28/21, when Dr. Mirkin opined he reviewed a 20-second video of Petitioner's job duties and did not appreciate significant overhead reaching that would aggravate Petitioner's pre-existing condition. Neither letter directed to Dr. Mirkin by Respondent was introduced into evidence. He stated his second opinion as to causation was based on the "definitions" provided by Respondent and the video.

The Arbitrator has viewed both videos marked Respondent's Exhibit 7. The first video depicts Petitioner performing his job duties as a pouch machine operator. The Arbitrator notes that Petitioner identified himself in the video at arbitration. The video is taken from an aerial view within the plant making it very difficult to discern the height of Petitioner compared to the boxes on the conveyor belt. The video is 24 seconds long. Petitioner is seen reaching at face level or higher to remove a box from the conveyor belt. Petitioner used his right arm in the video to remove the box. He testified the video was taken after his injury so he did not use his left arm as he normally would have to remove the box. The video depicts Petitioner removing only one box from the line. Unfortunately, his movement of removing the box with his right arm is blocked by a steel beam in the ceiling making it further difficult to ascertain the overhead activity.

The second video is a five second video that depicts a hand sliding boxes backward on the conveyor belt and removing one box. The video does not show the body of the person removing the box or the person's full arm or shoulder. However, Respondent's Safety Coorindator, Mr. Robertson, testified it is him depicted in the video. Mr. Robertson grabs ahold of a box and slides it and three boxes behind it backwards. He then lifts the box off the conveyor belt. It is not shown on the video if more than three boxes were behind the box being removed; however, Mr. Robertson testified there were 6 or 7 boxes behind the box he removed. The video does not depict whether the line was malfunctioning or working smoothly when Mr. Robertson removed the box.

The video depicts Mr. Robertson's arm at a 45° angle making it appear he was reaching above shoulder level to remove the box. Mr. Robertson testified he is 5'10" tall and the conveyor belt depicted in the video is 61 inches from the ground.

The Arbitrator relies on the credible opinions of Dr. DeGrange in finding causal connection between Petitioner's cervical spine condition and the 7/7/20 work accident. The Arbitrator finds Dr. Mirkin's opinions less persuasive as he initially found Petitioner's condition causally related to his injury and changed his opinion after reviewing a 20-second videotape that the Arbitrator does not find accurate or adequate for the reasons stated above.

Based upon the objective findings on Petitioner's imaging studies, the history in Petitioner's medical records, Petitioner's lack of any cervical spine injuries or symptoms prior to his accident on 7/7/20, and his persistent complaints of pain in his cervical spine

and radiculopathy in the left arm despite conservative treatment, the Arbitrator finds Petitioner met his burden of proof regarding causal connection. The chain of events and the medical evidence establishes that Petitioner's current condition of ill-being in his cervical spine is causally related to his work injury of 7/7/20.

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

In *Freesen, Inc., v. Industrial Comm'n*, the court listed three bases on which to include overtime hours into the calculation of average weekly wage: that (1) he was required to work overtime as a condition of his employment, (2) he consistently worked a number of overtime hours each week, ***or*** (3) the overtime hours he worked was part of his regular hours of employment. *Freesen, Inc., v. Industrial Comm'n,* 348 Ill.App.3d, 1035, 811 N.E.2d at 322 (2004). (emphasis added). The Commission has interpreted the case law to require that only one of the bases must be proven in order for the overtime hours to be included in the calculation of average weekly wage.

Petitioner testified he worked eight hours per shift and four hours overtime when required. He testified he often worked overtime and worked at least four hours overtime per week. He testified he could not refuse overtime without receiving a half point and the accumulation of too many points in a 12-month period would lead to termination. He testified that overtime is mandatory if enough employees did not volunteer. Overtime is based on seniority status. Petitioner testified he is the lowest in seniority on day shift and no evidence was introduced that Petitioner used his status to request overtime work.

Respondent's Safety Coordinator, Mr. Robertson, testified that overtime is voluntary *unless* there is a shortage of volunteers in which case overtime is *assigned* in rotation starting with the lowest senior employee. The Arbitrator notes that "assigned" means "mandatory" based on Mr. Robertson's testimony. The Arbitrator also notes that assigning overtime would start with Petitioner in rotation as he was the lowest senior employee. Mr. Robertson testified that if an employee refuses overtime he receives an attendance point. A written warning is issued after three points within a 12-month period. A total of nine points are allowed in a 12-month period before an employee is terminated.

The Arbitrator finds that Petitioner was required to work overtime as a condition of his employment. Therefore, the Arbitrator adopts Petitioner's average weekly wage calculation of $1,080.20 based on earnings during the year preceding the injury of $56,170.40.

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

Based on the Arbitrator's findings as to accident and causal connection, the Arbitrator finds Petitioner has not reached maximum medical improvement and is entitled to receive the additional care recommended by Dr. DeGrange, including, but not limited to, a posterior cervical discectomy and fusion at C4-5.

This award shall in no instance be a bar to further hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

Arbitrator Linda J. Cantrell

DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC008212
Case Name	SANTOS, ALEXANDRA P MACEDO v. MENARDS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0125
Number of Pages of Decision	25
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Jennifer Kelly
Respondent Attorney	Monica Fernandez

DATE FILED: 4/6/2022

/s/ Deborah Simpson, 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

Alexandra Macedo Santos,

Petitioner,

vs. NO: 19 WC 8212

Menards,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 19, 2021, 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 6, 2022

o3/30/22
DLS/rm
046

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

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC008212
Case Name	SANTOS, ALEXANDRA P MACEDO v. MENARDS
Consolidated Cases	
Proceeding Type	19(b) Petition & 8A
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	22
Decision Issued By	Molly Mason, Arbitrator

Petitioner Attorney	Jennifer Kelly
Respondent Attorney	Monica Fernandez

DATE FILED: 8/19/2021

/s/Molly Mason, Arbitrator
Signature

INTEREST RATE WEEK OF AUGUST 17, 2021 0.05%

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)

Alexandra Macedo Santos
Employee/Petitioner

v.

Menards
Employer/Respondent

Case # **19** WC **08212**

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 **July 19, 2021**. After reviewing all 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, **12/31/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

The parties agreed to defer the issue of average weekly wage to a future hearing.

On the date of accident, Petitioner was **55** 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 $**4,908.75** for TTD, $**2,133.26** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,042.01**.

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

ORDER

The Arbitrator determines that all lumbar spine medical treatment rendered to date has been reasonable and medically necessary. The Arbitrator awards the outstanding charges relating to lumbar spine care, including but not limited to the charges outlined in PX 6, pursuant to the fee schedule. For the reasons set forth in the attached decision, the Arbitrator finds that Respondent is NOT liable for the Suburban Orthopaedics charges relating to a 1/6/21 tendon sheath lesion excision and treatment of plantar fasciitis.

The Arbitrator orders Respondent to authorize and pay for the anterior lumbar fusion recommended by Dr. McNally, along with any pre-operative testing and/or imaging the doctor finds to be appropriate.

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.

Molly C Mason

Signature of Arbitrator

August 19, 2021

ICArbDec19(b)

Alexandra Macedo Santos v. Menard's
19 WC 8212

Summary of Disputed Issues

The parties agree that Petitioner, an assistant manager, sustained an accident on December 31, 2014, while working for Respondent. Petitioner testified she experienced an abrupt onset of low back pain radiating down her left leg while she was transferring 50-pound bags of dog food from a pallet to a cart. She denied seeking back-related care prior to this accident but acknowledged having experienced occasional back pain while working. She did not immediately report the accident or seek treatment because she hoped she would improve. On January 8, 2015, she reported the accident to a front end manager, who directed her to Alexian Brothers. That facility, in turn, referred her to Dr. McNally, who initially recommended pain management with Dr. Novoseletsky and later performed a lumbar discectomy on October 3, 2016. Respondent's Section 12 examiner, Dr. Mohan, found this surgery to be appropriate. After a course of therapy and work conditioning, Dr. McNally released Petitioner to unrestricted work on February 28, 2017 but directed her to return to him in two months. Petitioner testified that, when she returned to work, she stepped down from her assistant manager job and began performing a less strenuous inventory control job. Petitioner remained symptomatic after returning to work. At Dr. McNally's direction, she resumed pain management and underwent additional injections by Dr. Belmonte in 2017, after declining to undergo a spinal cord stimulator trial recommended by Dr. Novoseletsky. Eventually, Dr. McNally recommended a second surgery, an anterior lumbar fusion. In a report issued on April 3, 2018, Dr. Mohan opined that the fusion was not appropriate based on his reading of a 2017 MRI and a lack of correlation between the objective findings and Petitioner's subjective complaints. Mohan Dep Exh 3. Dr. McNally disagreed with certain of Dr. Mohan's opinions and continued to recommend the fusion. He imposed work restrictions in November 2020.

As of the Section 8(a) hearing of July 19, 2021, Petitioner remained under Dr. McNally's care and was continuing to work in inventory control. She testified she remains symptomatic and wants to undergo the recommended fusion.

On the morning of the hearing, Respondent raised an issue as to Petitioner's average weekly wage. The parties agreed to defer this issue to a future hearing. Arb Exh 1.

The disputed issues include causal connection, medical expenses and prospective care. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she began working for Respondent on October 16, 2008. She was an assistant manager in the wall covering department. Her duties included stocking and merchandising. She was required to lift up to 50 pounds.

Petitioner acknowledged experiencing occasional, activity-related lower back pain prior to the accident of December 31, 2014, but denied seeking care for this pain. She felt fine when she reported for work on December 31, 2014. Near the end of her shift, she was lifting 50-pound bags of dog food and transferring them from a pallet to a cart, when she experienced an abrupt onset of lower back pain radiating down her left leg. She managed to finish her shift and then went home. Initially, she felt as if she would likely improve but began to realize she was actually getting worse. On January 8, 2015, she reported the work accident to a front end manager and completed an accident report. The manager then sent her to Alexian Brothers Corporate Health. The records from this facility set forth a consistent history of the work accident, with Petitioner indicating she was still experiencing low back pain radiating to her left leg. PX 1. The examining provider, Glenn Garafolo, PA-C, ordered lumbar spine X-rays, which showed degenerative disc changes at L1-L2. On examination, Garafolo noted mild tenderness over the left lumbar paraspinal muscles and left SI joint, negative straight leg raising and no weakness. Garafolo diagnosed a lumbar strain. He imposed various restrictions and prescribed Flexeril and Ibuprofen, along with home exercises. PX 1.

Petitioner returned to Alexian Brothers on January 14, 2015, as directed, and again saw Garafolo. Petitioner complained of lower back pain radiating to her upper left leg. Garafolo discontinued the Ibuprofen and continued the Flexeril and restrictions. PX 1.

At the next visit, on January 20, 2015, Garafolo continued the restrictions and prescribed eight sessions of physical therapy. PX 1.

Following the therapy, Petitioner returned to Alexian Brothers on March 4, 2015, and indicated she was still experiencing low back pain radiating to her left leg. Garafolo continued the restrictions and Flexeril and prescribed a Prednisone dose pack and a lumbar spine MRI. PX 1.

The lumbar spine MRI, performed without contrast on March 23, 2015, showed bulging of the L1-L2 disc, diffuse bulging at L4-L5 narrowing the foramina and bulging at L5-S1 causing minimal left foraminal narrowing. PX 2.

Petitioner returned to Alexian Brothers on March 27, 2015, and again saw Garafolo. Petitioner indicated she remained symptomatic and had recently undergone an MRI. Garafolo noted positive straight leg raising at 80 degrees. He continued the work restrictions and referred Petitioner to Dr. McNally, an orthopedic surgeon. PX 1, 2.

Petitioner testified she first saw Dr. McNally on April 16, 2015. She provided a history of the work accident to the doctor and indicated she was experiencing low back pain radiating down her left leg. She also indicated she was currently performing restricted duty. The doctor acknowledged Garafolo's referral. He noted that, prior to the accident, Petitioner "had been experiencing intermittent bouts of pain through the lower back associated with lifting activity from work" for which she took over the counter medication. He also noted that the accident

"moderately exacerbated" these symptoms. He indicated that Petitioner had fallen at work in 2012 but that this fall resulted in an injury to the neck, not the back.

Dr. McNally described Petitioner's gait as reciprocal. On examination, he noted no sciatic notch tenderness and negative straight leg raising bilaterally. He obtained X-rays and interpreted the films as demonstrating degenerative changes. After reviewing the MRI, he indicated he basically agreed with the radiologist's interpretation but also noted a "far lateral disc herniation at L4-L5 to the left." He diagnosed lumbar disc displacement and lumbar spinal stenosis. He discussed surgical options with Petitioner but indicated he found it reasonable for her to "maximize her non-operative care" with pain management. He prescribed Meloxicam and a repeat Medrol dose pack. He referred Petitioner to his partner, Dr. Novoseletsky, for injections and directed Petitioner to restart physical therapy after the first injection. He continued the previous restrictions. PX 2.

Petitioner first saw Dr. Novoseletsky on June 4, 2015. Petitioner complained of 8/10 low back pain radiating down her legs into her feet. She also reported she was having difficulty sleeping. On examination, Dr. Novoseletsky noted a limited range of motion, pain with extension and positive straight leg raising on the left. He described Petitioner's gait as antalgic. He obtained lumbar spine X-rays, which showed degenerative changes and no instability. He prescribed a NSAID compound cream, Neurontin, Flexeril and a left L4-L5 epidural steroid injection. PX 2.

Dr. Novoseletsky administered the recommended injection on July 14, 2015. On July 23, 2015, Petitioner returned to the doctor and reported 20% improvement "for the first couple of days" following the injection. She rated her pain at 7/10 and indicated she was still having difficulty sleeping. The doctor recommended a second injection and indicated he was also considering a left greater trochanter bursa injection. PX 2.

Petitioner underwent an initial evaluation at Suburban Physical Therapy on July 21, 2015. Petitioner provided a history of the work accident and reported minimal pain relief from the recent injection. PX 3.

Dr. Novoseletsky administered a second epidural injection, at L5-S1, on August 12, 2015. PX 2.

On August 27, 2015, Petitioner returned to Dr. Novoseletsky and reported about 80% relief from the second injection. Petitioner indicated she was still experiencing 6/10 low back and left leg pain. She also reported that her leg pain was sometimes severe enough to bring her to tears. The doctor recommended another injection. PX 2.

Petitioner underwent a third injection, at left S1, on September 16, 2015. PX 2.

A physical therapy note dated September 22, 2015 reflects that Petitioner denied low back pain but complained of pain starting in her left hip joint radiating down to her knee and the top of her foot. PX 3.

On October 2, 2015, Petitioner returned to Dr. Novoseletsky and indicated her back was better but her left leg pain was unchanged. She rated her pain at 10/10 and indicated that much of it was located along the lateral aspect of her left hip. The doctor administered a greater trochanter bursa injection. PX 2.

On October 15, 2015, Petitioner reported to her physical therapist that she had not experienced back pain for over a month but was still experiencing left hip pain radiating down the front of her thigh to her knee. PX 2, 3.

On December 22, 2015, Dr. Novoseletsky administered a left sacroiliac joint injection. PX 2.

On February 5, 2016, Petitioner returned to Dr. Novoseletsky and reported no relief from the most recent injection. Petitioner indicated her main concern was her left buttock and leg pain. The doctor recommended that she return to Dr. McNally to discuss surgical options. PX 2.

Dr. McNally met with Petitioner on February 23, 2016. Petitioner indicated her low back pain had improved but she again complained of left leg pain radiating to her foot with associated tingling. Petitioner also reported that the injections and therapy did not relieve her symptoms. The doctor reviewed the previous imaging studies and discussed various options with Petitioner, indicating that she might improve over time without undergoing surgery but that surgery usually provided a "predictably faster relief of lower extremity radicular pain." He prescribed an updated closed lumbar spine MRI and bilateral lower extremity EMG/NCS testing. PX 2.

The closed MRI, performed on March 10, 2016, showed mild bilateral foraminal stenosis at L5-S1, secondary to inferior foraminal disc bulging, and mild lumbar spondylosis at L1-L2 and L4-L5. The radiologist described these findings as "unchanged" since the original MRI of March 23, 2015. PX 2.

On March 24, 2016, Dr. McNally noted that Petitioner continued to complain of constant pain in her anterior left leg down to her foot. He indicated that the EMG/NCS testing had not been performed, "due to authorization status issues," but that Petitioner had undergone the closed MRI. He interpreted the latter as showing stenotic foramens on the left at L4-L5 and L5-S1, "consistent with [Petitioner's] complaints." He again recommended EMG/NCS testing, followed by a left L5-S1 laminotomy and possible left L4-L5 laminotomy. He described decompressive surgery as "relatively well tolerated type surgeries versus fusion surgery which is considered major surgery with increased risks and longer recovery."

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Mohan, an orthopedic surgeon, on March 30, 2016. In his report of the same date (Mohan Dep Exh 2), Dr. Mohan recorded a consistent history of the lifting-related work accident and subsequent medical care. He noted that, despite therapy and a series of injections, Petitioner was still experiencing left buttock pain radiating to her anterior thigh and down her anterior leg to the dorsum of her left foot. He described Petitioner as able to sit comfortably in his examination room and able to toe and heel walk without difficulty. On examination, he noted no tenderness to palpation of the lumbar spine, no pain with hip range of motion, positive Faber testing on the left only, negative straight leg raising bilaterally, 5/5 strength, paresthesias in the left L2 and "possibly L5 dermatome" and positive femoral nerve stretch testing on the left. He obtained lumbar spine X-rays and interpreted the films as showing "disk degeneration at multiple levels, most notably at L1-L2" and "mild disc height loss at the L4-L5 level as well." He interpreted the March 23, 2015 MRI images as showing disc bulging at L1-L2, L4-L5 and L5-S1 but "no significant stenosis." He indicated he also reviewed records from Glenn Garafolo, PA-C, Dr. McNally and Dr. Novoseletsky, along with various physical therapy notes.

Based on his examination and records review, Dr. Mohan diagnosed left lumbar radiculopathy. He described this diagnosis as "tentative," indicating that Petitioner's radicular symptoms did not follow typical dermatomal patterns. He noted that Petitioner's history of injury correlated with the aggravation of her pre-existing disc disease. He went on to state that "the lifting of the 55-pound bags likely aggravated [Petitioner's] lumbar spine and led to her lower back strain and possible lumbar radiculopathy." He agreed with the need for EMG/NCS testing, as recommended by Dr. McNally, and recommended that Petitioner undergo a left lumbar decompressive procedure if the testing proved positive. He noted that Petitioner "does not have any Waddell signs or abnormal pain behaviors" but indicated her subjective complaints did not correlate very well with her MRI findings.

On May 9, 2016, the claims adjuster, Thomas Broeder, sent Dr. McNally a copy of Dr. Mohan's report and provided authorization for the EMG/NCS testing. PX 2.

The EMG/NCS testing, performed by Dr. Lopez on May 25, 2016, showed "evidence of chronic left S1 radiculopathy" with no nerve entrapment, plexopathy or myopathy. PX 2.

Dr. McNally operated on October 3, 2016, performing decompressive laminotomies on the left at L4-L5 and L5-S1. Following the surgery, he prescribed a Medrol DosePak. PX 2.

On October 20, 2016, Petitioner followed up with Dr. McNally and complained of "new pain" in her left shin, calf and foot. She indicated her left thigh pain had resolved. The doctor prescribed a second Medrol DosePak as well as a repeat MRI and Meloxicam.

The repeat MRI, performed with and without contrast on November 4, 2016, showed left-sided postoperative changes at L4-L5 and L5-S1, "enhancement of the intradural left L5 nerve root consistent with radiculitis," no new disc herniation and degenerative disc disease at L1-L2. PX 2.

Petitioner underwent an initial physical therapy evaluation on November 23, 2016. During the evaluation, she reported decreased pain following the laminotomy but persistent numbness and tingling along her left foot. PX 3.

A physical therapy note dated December 13, 2016 reflects that Petitioner reported improvement but was still experiencing pain and left foot numbness and tingling. PX 3.

On December 15, 2016, Dr. McNally noted that Petitioner was "manag[ing] to get through her daily activities" but was still trying to limit herself. He directed Petitioner to continue therapy and progress to work conditioning. He released Petitioner to light duty, with lifting up to 10 pounds, and refilled her medications. PX 2.

On January 24, 2017, Petitioner returned to Dr. McNally and indicated she had finished therapy and was scheduled to begin work conditioning. She reported pain levels of 6-7/10 depending on her activity level. The doctor instructed her to start work conditioning. PX 2.

Petitioner underwent an initial work conditioning evaluation on January 26, 2017. She participated in work conditioning for about two weeks thereafter and reported gains in strength. A progress report dated February 16, 2017 reflects that she reported minimal to no pain along the lumbar region and a decrease in her left-sided radicular symptoms. The evaluator found that she did not demonstrate the capabilities necessary to perform her job. She recommended two additional weeks of work conditioning. PX 3.

On February 28, 2017, Petitioner returned to Dr. McNally and reported that she was performing light duty five hours per day. Petitioner reported improvement following the surgery and indicated her symptoms varied depending on her activity level. She expressed a desire to return to work and rated her pain at 1/10. The doctor released her to full duty but directed her to follow up in two months. PX 2.

On April 25, 2017, Petitioner returned to Dr. McNally and indicated she was still experiencing low back pain as well as pain in the anterior portion of her right leg. Dr. McNally referred Petitioner back to Dr. Novoseletsky for evaluation and treatment of her right-sided symptoms. PX 2.

On May 5, 2017, Petitioner returned to Dr. Novoseletsky and complained of ongoing low back pain radiating down both legs, worse on the right. The doctor discussed placement of a spinal cord stimulator with Petitioner and referred her to Dr. Lofland for a pre-procedural psychological evaluation. PX 2.

On June 20, 2017, Petitioner returned to Dr. McNally and described her symptoms as unchanged. She expressed a preference for a second surgery over a spinal cord stimulator. The doctor referred her to Dr. Belmonte for consideration of additional injections. PX 2.

On July 5, 2017, Petitioner saw Dr. Belmonte. The doctor recorded a history of the work accident and subsequent care. He noted complaints of intermittent low back achiness, worse at night, along with pain radiating down both legs to the feet and minor leg weakness when standing. He indicated that Petitioner described her right leg pain as "now severe." He noted that Petitioner was continuing to work despite her symptoms. He recommended right-sided L5-S1 transforaminal epidural steroid injections. On October 18, 2017, following three such injections, he noted that Petitioner reported substantial pain relief but was still symptomatic. He recommended that Petitioner follow up with Dr. McNally. PX 3.

Petitioner returned to Dr. McNally on December 12, 2017 and reported some improvement following the three injections. Petitioner complained of localized lower back pain, worse on the right, and pain radiating into her right gluteus and down her right leg to her knee. The doctor described her MRI finding of foraminal narrowing on the right at L5-S1 as "consistent with her low back and right leg symptoms." He recommended a repeat MRI. PX 2.

The repeat MRI, performed without contrast on December 23, 2017, showed post-surgical changes, disc bulges at L1-L2, L4-L5 and L5-S1, moderate left and mild right neural foraminal stenosis at L5-S1 and mild to moderate left and mild right neural foraminal stenosis at L4-L5. PX 2.

On February 1, 2018, Dr. McNally reviewed the MRI results with Petitioner and noted that Petitioner's leg symptoms were now bilateral. He found the symptoms "consistent with the collapse of the L5-S1 disc and foraminal narrowing." He discussed surgical options with Petitioner and referred her to Dr. Barnett, a general surgeon, for evaluation of a possible L5-S1 anterior approach fusion. PX 2.

On March 13, 2018, Dr. McNally noted Dr. Barnett's findings and recommended an L5-S1 anterior lumbar fusion. He advised Petitioner of the risks associated with this surgery. PX 2.

At Respondent's request, Dr. Mohan re-examined Petitioner on April 3, 2018. In his report of the same date, Dr. Mohan noted negative straight leg raising and indicated that Petitioner complained of numbness in her legs but "[could] not give a clear dermatome." The doctor interpreted the December 23, 2017 MRI as showing no significant stenosis at any level. He opined that Petitioner "has no clinical diagnosis that could correlate with her complaints." He found Petitioner capable of full duty but indicated she could undergo a functional capacity evaluation if she felt unable to resume unrestricted work. He characterized the injections performed by Dr. Belmonte and the decompressive surgery performed by Dr. McNally as "reasonable and necessary for [Petitioner's] condition." He did not find the recommended fusion to be appropriate, based on the MRI findings and the lack of correlation between his objective findings and Petitioner's complaints. Mohan Dep Exh 3.

On May 24, 2018, Petitioner returned to Dr. McNally and indicated she was still experiencing low back pain, pain radiating down both legs and intermittent left foot numbness and tingling. Dr. McNally reviewed Dr. Mohan's report. He indicated he disagreed with Dr.

Mohan's statement that the 2017 MRI showed only minimal stenosis. He also disagreed with the doctor's opinion that the recommended fusion was not appropriate. He ordered a repeat MRI and EMG/NCV testing. PX 2.

A repeat lumbar spine MRI performed on May 31, 2018 showed an L1-L2 protruding disc with mild impingement of the dural sac "similar to previously", L4-L5 and L5-S1 left hemilaminectomy defects and "asymmetric left foraminal encroachment at L5-S1 where there may be referred pressure on the exiting left L5 nerve root." PX 2.

Dr. Goldvekht conducted the recommended bilateral lower extremity EMG/NCV testing on August 21, 2018. He described the findings as suggestive but not providing definitive evidence of L5 radicular disease bilaterally. PX 2.

On September 25, 2018, Dr. McNally reviewed the MRI and EMG/NCV results with Petitioner. He noted that Petitioner remained symptomatic and wanted to proceed with the recommended fusion. PX 2.

On January 8, 2019 and February 21, 2019, Dr. McNally noted that Petitioner remained symptomatic but was continuing to work. He again recommended an anterior lumbar fusion. PX 2.

Petitioner returned to Dr. McNally on April 2, 2019. The doctor noted that Petitioner was still experiencing lower back pain and now had bilateral leg pain. He again noted that Petitioner wanted to proceed with an anterior fusion. PX 2.

On June 18, 2019, Petitioner saw Dr. McNally again and described her symptoms as unchanged. Petitioner rated her pain at 6/10. The doctor again recommended the fusion. PX 2.

A repeat lumbar spine MRI performed on January 20, 2020 showed an "overall stable appearance of the lumbar disc pathology" with the radiologist noting a small disc herniation at L1-L2, L4-L5 and L5-S1 left hemilaminectomy defects and "querry referred pressure on the left L5 nerve root." PX 2.

On July 14, 2020, Petitioner returned to Dr. McNally and complained of "more intense" symptoms, rated 7/10. The doctor refilled the Naproxen and referred Petitioner to Dr. Belmonte for pain management while awaiting approval of the fusion. PX 2.

On August 25, 2020, Petitioner returned to Dr. McNally and complained of worsening lower back pain and "more pain in her feet recently." She indicated she had not yet seen Dr. Belmonte "due to approval issues." The doctor refilled the Naproxen and again referred Petitioner to Dr. Belmonte for pain management while awaiting approval of the surgery. PX 2.

Petitioner continued seeing Dr. McNally thereafter. Bills from Suburban Orthopaedics (PX 6) reflect that, in September 2020, Petitioner began a course of care for foot and ankle problems, including plantar fasciitis. It appears she engaged in therapy, underwent bilateral foot X-rays, received orthotics and had a surgical procedure on January 6, 2021. [The Arbitrator notes that Petitioner did not testify about this treatment.] On November 17, 2020, Dr. McNally noted that Petitioner "continues to work with pain." He imposed various restrictions, including no lifting over 20 pounds, no kneeling or climbing and no repetitive bending or twisting. On December 29, 2020, the doctor noted that Petitioner remained symptomatic and "has wished" to undergo the recommended fusion "since February of 2018." PX 2. On February 9, 2021, Dr. McNally discontinued the Naproxen after Petitioner told him she had started taking blood thinners due to a blood clot in her leg. On June 15, 2021, the last visit prior to the hearing, Dr. McNally noted that Petitioner described her symptoms as having worsened due to "working more." The doctor again recommended the fusion. PX 2.

Dr. McNally testified by way of evidence deposition on March 18, 2021. PX 5. The doctor testified he is a board certified orthopedic surgeon. After medical school and a residency, he participated in spine surgery fellowship training at Rush University Medical Center. PX 5, pp. 5-6. He has been performing surgery since 2002. He has been affiliated with Suburban Orthopaedics since November 16, 2007. PX 5, pp. 6-7. McNally Dep Exh 1.

Dr. McNally testified he "literally spent hours and hours talking" with Petitioner but would need to refer to his notes while testifying. PX 5, p. 8. He first saw Petitioner on April 16, 2015. His records reflect that an Alexian Brothers clinic referred Petitioner to him. PX 5, p. 9. Petitioner provided a history of her lifting-related work accident of December 31, 2014. Petitioner also told him she had occasionally experienced aches and pains in her low back while working before December 31, 2014 but that the accident of that date caused an abrupt onset of sharp low back pain. PX 5, p. 11. With respect to the consistency of Petitioner's reporting, the doctor indicated that Petitioner has been "pretty straight forward over the years." PX 5, p. 11. Petitioner complained of low back soreness and shooting pain through her left leg. She reported only "mild relief" from physical therapy. PX 5, p. 11.

Dr. McNally testified that, on initial examination, he noted "a little bit of limitation in range of motion" of the low back but "nothing specific." He concurred with the radiologist's reading of the lumbar spine MRI but also noted a far lateral disc herniation on the left at L4-L5. PX 5, p. 13. He diagnosed lumbar disc displacement and lumbar spinal stenosis. He recommended that Petitioner see Dr. Novoseletsky for pain management. PX 5, p. 14. Petitioner returned to him ten months later, having undergone three lumbar epidural steroid injections in the interim. When Petitioner returned, she reported some improvement of her lower back pain but indicated she was still experiencing persistent left leg pain. Thereafter, Dr. Novoseletsky administered two trochanter bursa injections the left hip and an SI joint injection. In February 2016, Dr. Novoseletsky referred Petitioner back to him. He saw Petitioner on February 23, 2016, at which time she reported improvement of her low back pain but persistent left leg pain radiating to her foot. Petitioner also reported being unable to sit or stand for long periods. PX 5, p. 17. He ordered new imaging and EMG/NCV testing. He also restricted

Petitioner to light duty. PX 5, p. 17. The repeat MRI, which was closed, showed narrowing in the foramen on the left at L4-L5 and L5-S1, "consistent with" Petitioner's symptoms. PX 5, pp. 18-19. Following EMG/NCV testing, Petitioner came back again on June 16, 2016. The testing showed evidence of chronic left S1 radiculopathy, which was "consistent with the MRI imaging." PX 5, p. 20. Petitioner had also undergone an examination by Dr. Mohan, with that doctor concurring with the course of care. PX 5, p. 21.

Dr. McNally testified that, on June 16, 2016, he recommended that Petitioner undergo left L4-L5 and L5-S1 laminotomies to relieve her left leg pain. After workers' compensation provided authorization, he performed this surgery on October 3, 2016. His postoperative diagnosis was consistent with his preoperative diagnosis. He took Petitioner off work as of the surgery. PX 5, pp. 21-22. To his knowledge, Petitioner had been performing light duty prior to the surgery. PX 5, p. 22. On October 20, 2016, he ordered another MRI to address Petitioner's complaints of left shin and calf pain. He wanted to make sure there was no recurrent disc herniation. The repeat MRI showed inflammation at L4-L5 and L5-S1 on the left. It also showed evidence of radiculitis, which was consistent with Petitioner's report of increased leg pain. PX 5, p. 23. On December 15, 2016, he released Petitioner to light duty and recommended that she continue medication and therapy. PX 5, pp. 23-24. On January 24, 2017, Petitioner reported having "good days and bad days" in terms of her low back pain and persistent, albeit somewhat improved, left leg pain. He recommended that Petitioner engage in work conditioning. At the next visit, on February 28, 2017, he released Petitioner to full duty but did not discharge her from care. Petitioner returned to him on April 25, 2017 and reported persistent low back and left-sided pain along with new right-sided symptoms. Dr. McNally found the new right-sided symptoms consistent with the MRI, which showed narrowing at L5-S1. Unfortunately, it is not uncommon for postoperative patients to experience radiating pain on the opposite side. PX 5, pp. 27-28. Any spine surgery "changes the architecture of the spine," which can result in decreased disc height and more pressure on the nerve on the opposite side. When he operated on Petitioner, he removed a lot of the L5-S1 facet joint on the left and this placed an "increased load" on the other side. PX 5, pp. 29-30. Causation "goes back to the original insult to the nerves and then the course of treatment." PX 5, p. 30. He again recommended that Petitioner see Dr. Novoseletsky. PX 5, p. 30. Petitioner returned to him on June 20, 2017 and complained of bilateral low back pain radiating to her right thigh and knee. PX 5, p. 31. He and Petitioner discussed Dr. Novoseletsky's recommendation of a thoracic spinal cord stimulator trial. He (Dr. McNally) felt it was "a little early to talk about a spinal cord stimulator," given that only eight or nine months had passed since the surgery. He recalled Petitioner saying that, if she had to undergo a laminotomy to get the stimulator into place, she would prefer to have the same surgery on the right that she had previously had on the left. Petitioner thought the stimulator was "a little aggressive" so he recommended another epidural steroid injection, on the right. PX 5, p. 33. He referred Petitioner to Dr. Belmonte for consideration of this injection. He also found Petitioner capable of continuing full duty. PX 5, pp. 33-34.

Dr. McNally testified he next saw Petitioner on December 12, 2017. By that time, Petitioner had undergone three epidural injections by Dr. Belmonte. Petitioner reported that

her pain was less intense but that it persisted in her low back and was a little worse on the right. Petitioner complained of pain in the right buttock and down the right leg to the knee. He recommended another MRI. Petitioner underwent this study on December 23, 2017. The MRI showed evidence of the prior left laminotomies and stenosis, worse at L5-S1 than L4-L5. At the next visit, on February 1, 2018, Petitioner complained of low back pain and bilateral leg pain. PX 5, p. 35. Petitioner also complained of tingling in her left foot. PX 5, p. 36.

Dr. McNally testified he referred Petitioner to Dr. Barnett, a general surgeon, for a consultation concerning an anterior approach for the recommended surgery. An anterior approach allows for "indirect decompression. . . without having to go back through the patient's spine muscle, back muscle, and without having to directly manipulate the joints in the back." The narrowing at L5 and S1 is consistent with Petitioner's radicular complaints. PX 5, p. 39. He recommended surgery because time had passed and Petitioner had failed to respond to various conservative measures. PX 5, p. 41. Petitioner returned to him on March 13, 2018, after seeing Dr. Barnett, and he again explained to her why he was recommending a fusion rather than a different surgery. Petitioner failed to experience significant benefit from the initial decompression on the left and had started having symptoms on the contralateral side. A surgeon can "do a wider decompression [with a fusion] than if you do just a laminotomy." If he went back in and just opened up the foramens again, there would be a chance that the spine could destabilize and Petitioner could require another surgery "down the line." PX 5, pp. 42-43. He reviewed Dr. Mohan's report and disagrees with the doctor's opinions that there is no radiculopathy and that the stenosis is minimal. PX 5, pp. 44-45. The EMG that Dr. Goldvekht performed showed evidence of L5 radiculopathy bilaterally and the updated MRI of May 31, 2018 showed stenosis at L5-S1 that was probably a little bit worse. PX 5, pp. 46-47.

Dr. McNally testified he saw Petitioner on a number of occasions between October 2018 and February 2021. The fact that Petitioner continued performing full duty during this time does not mean she does not need surgery. Rather, it is a "testament that [Petitioner] is a hard worker" and pushes through pain. PX 5, p. 50. A new MRI, performed on January 20, 2020, showed a "new disc herniation at L3-L4 to the left." PX 5, p. 51. He does not believe this new finding changed anything significantly. The new herniation was not causing Petitioner's leg symptoms. PX 5, p. 51. The new MRI demonstrated ongoing pressure on the L5 nerve root. PX 5, p. 52. At the December 29, 2020 visit, Petitioner reported being able to walk for only one hour. Petitioner previously reported being able to walk as far as she needed to. PX 5, pp. 53-54.

Dr. McNally opined that Petitioner's current lumbar condition is causally related to the December 31, 2014 work accident. He further opined that the work accident brought about the need for the October 3, 2016 surgery as well as the need for the fusion he is recommending. PX 5, pp. 55-56. Before the accident, Petitioner had "minimally symptomatic low back issues." Afterward, her back pain increased and she had radicular symptoms. PX 5, p. 56. Petitioner had degenerative changes before the work accident but "they weren't really bothering her." The accident aggravated those changes. PX 5, pp. 56-57. There is no evidence indicating Petitioner underwent formal low back testing or treatment before the work accident. PX 5, p.

57. He has treated Petitioner for almost six years and finds her to be a credible historian. Petitioner's symptoms are consistent with the objective findings and diagnostic studies. PX 5, p. 58. The recommended fusion would hopefully cause Petitioner's back and leg pain to improve. Petitioner would have abdominal pain immediately after the surgery, due to the anterior approach, but that would improve over time. The back pain often improves right away. PX 5, p. 59.

Under cross-examination, Dr. McNally testified he performs over 200 surgeries per year. Of these surgeries, about 100 are lumbar fusions. Although he is technically a surgeon, most of his patients do not undergo surgery. PX 5, pp. 60-61. He believes he has testified in other cases involving Petitioner's law firm but he has no idea how many times this has occurred. His deposition fee goes to his practice rather than to him personally. PX 5, p. 61. He performs about one IME per year. PX 5, p. 61. He has performed about twenty IMEs during his career. These IMEs were split fairly evenly between claimants and employers. He first saw Petitioner on April 16, 2015. PX 5, p. 62. Petitioner's MRI shows that her left-sided facet joint is smaller than her right because he removed some of it "to make room." PX 5, p. 63. He agrees with the radiologist that Petitioner's stenosis is moderate on the left and milder on the right. That is consistent with Petitioner's symptoms. PX 5, p. 63. In Petitioner's case, the stenosis is degenerative. PX 5, p. 64. After his initial visit with Petitioner, he did not see her again for ten months. During that period, Petitioner saw Dr. Novoseletsky, at his recommendation, for conservative care. PX 5, p. 65. He discussed surgery with Petitioner at the first visit but she was nervous and really did not like the idea of undergoing an operation, "which is completely normal." PX 5, p. 65. He does not believe he noted positive straight leg raising when he examined Petitioner. It is "often present but not always." PX 5, p. 66. Dr. Mohan's observations of Petitioner are consistent with his own, with the exception of Petitioner's presentation right after surgery. PX 5, p. 67. In February 2017, after work conditioning, he released Petitioner to full duty but told her to return to him in two months. PX 5, p. 69. He initially did not recommend a fusion because Petitioner's back pain improved with injections. The surgery he performed in 2016 was intended to address the left leg pain. PX 5, p. 69. It has not been proven to him that a person's weight contributes to disc degeneration. "There are plenty of slender people with degenerative disc disease." PX 5, p. 70. The need for the fusion stems from a combination of factors, including the work accident. PX 5, p. 71. As of February 2017, when he released Petitioner to full duty, Petitioner still had radicular symptoms. PX 5, p. 71. At that time, Petitioner characterized those symptoms as minimal. Petitioner indicated her left leg pain would worsen with activity. PX 5, p. 72. Petitioner "never returned to baseline." PX 5, p. 73. Petitioner was "tough enough to keep working even with symptoms." He tells his patients that he can only improve their situation. He never tells them they will be free of pain following surgery. PX 5, p. 73. Some patients do better than others following a laminotomy. He had no reason to keep Petitioner off work after the work conditioning since she could tolerate it. He would most likely order a repeat EMG before performing a fusion. PX 5, p. 75. It was the work accident that caused Petitioner's symptoms. PX 5, p. 77. He would not be recommending a fusion if Petitioner had a normal disc. PX 5, p. 79.

On redirect, Dr. McNally testified that he deferred to pain management, i.e., Dr. Novoseletsky, during the ten months he did not see Petitioner following her initial visit. There is a degenerative component to Petitioner's lumbar spine condition but the work accident was an aggravating factor. PX 5, p. 81. Positive straight leg raising does not have to be present in order for a patient to have radiculopathy. PX 5, pp. 82-83. The fact that Dr. Mohan described Petitioner as walking without difficulty does not prompt him to change his causation opinion or surgical recommendation. PX 5, p. 83. It does not surprise him that Petitioner's symptoms increased after she resumed full duty in 2017. PX 5, p. 84. Petitioner had degenerative changes before the surgery "but the surgery made them worse." PX 5, p. 85.

Under re-cross, Dr. McNally testified that the fusion he is recommending is intended to treat, but not necessarily cure, the stenosis and resultant symptoms. PX 5, p. 87. He cannot say, percentage-wise, how much the surgery caused the degeneration to worsen. Before the surgery, Petitioner did not have right-sided symptoms. PX 5, pp. 88-89. Hypothetically, it is possible that the loss of disc height would be the same now, even if the surgery had not taken place. PX 5, p. 89.

Dr. Mohan testified by way of evidence deposition on June 8, 2021. RX 1. Dr. Mohan identified Mohan Dep Exh 1 as his current CV. He obtained an engineering degree at Cornell and then attended medical school at the University of Illinois. After his residency, he underwent spine surgery fellowship training at UC Davis. He then returned to the University of Illinois. He has been in practice since 2011. He started his own practice 2 ½ years ago. RX 1, pp. 5-6. He is board certified in orthopedic surgery. RX 1, p. 6.

Dr. Mohan testified he examined Petitioner on March 30, 2016 and April 3, 2018. He acknowledged he needs to refer to his notes since several years have passed since he saw Petitioner. RX 1, p. 7. He identified Mohan Dep Exh 2 as the report he generated on March 30, 2016. RX 1, p. 7. In connection with his first examination he reviewed records from Alexian Brothers, Dr. McNally and Dr. Novoseletsky. He did not document the X-ray results of January 8, 2015 but the X-rays he obtained on March 30, 2016 showed disc degeneration at multiple levels, most notably at L1-L2, no instability and no spondylolisthesis. RX 1, p. 9. Petitioner told him she experienced increased back pain at work while repeatedly lifting bags of dog food that weighed approximately 55 pounds apiece. She continued working following this event. When he examined her, he noted that she could walk and bend without difficulty. FABER testing was positive on the left. Straight leg raising was negative but Petitioner did have a positive femoral nerve stretch test on the left. Petitioner complained of pins and needles in the L2 and L5 dermatomes on the left but "these were not clearly defined." RX 1, p. 13.

Dr. Mohan testified that his working diagnosis was lumbar radiculopathy but that "the radicular findings were not definitive because they were in multiple regions." Similarly, the MRI findings were "not severe in any one particular location." RX 1, p. 13. He found it difficult to gauge where the radicular symptoms were coming from. RX 1, pp. 13-14. He concurred with Dr. McNally's recommendation of EMG/NCV testing. In his opinion, the work accident "did aggravate [Petitioner's] previously degenerative lumbar spine and led to the lower back strain

and possible radiculopathy." RX 1, p. 14. He felt the EMG/NCV testing was necessary because the leg findings were not well defined. If those symptoms did not show up on the EMG/NCV they might not need to be treated. RX 1, p. 14. Petitioner "had prior back problems but repeated lifting of the 55-pound bags aggravated her lower back and led to her current condition." RX 1, p. 15. There were some discrepancies, however. For example, if Petitioner had a herniation at L1-L2, that could cause thigh symptoms but it would not cause leg symptoms radiating to the foot. RX 1, p. 15.

Dr. Mohan testified that, when he re-examined Petitioner, on April 3, 2018, he reviewed Dr. McNally's records, including his operative report, and a follow-up MRI. He also reviewed the May 25, 2016 EMG/NCV, which showed distinctive S1 radicular findings. RX 1, p. 17. When Petitioner saw Dr. King, on October 4, 2016, she was happy with her progress and walking without difficulty. RX 1, p. 18. At the re-examination, Petitioner indicated she was still experiencing left-sided low back pain radiating to her buttocks. Petitioner also indicated she was experiencing numbness all the way down her legs. She "could not give a clear dermatomal pattern." RX 1, p. 21. Petitioner's neurologic examination was normal and her functional examination was "beyond normal." His working diagnosis was lumbar degenerative disc disease. "There was no more further evidence of radiculopathy." RX 1, p. 22. The lumbar degenerative disc disease pre-dated the work accident. Petitioner was not able to delineate her dermatomal complaints. The medical treatment predating his re-examination was reasonable and necessary. RX 1, p. 24. Further surgery was not indicated. A functional capacity evaluation was an option if Petitioner felt she could not continue to perform full duty. RX 1, p. 24.

Dr. Mohan testified he is aware that Dr. McNally is recommending an anterior fusion at L5-S1. RX 1, p. 24. He disagrees with this recommendation "due to lack of objective findings." RX 1, p. 25. Mohan Dep Exh 3, p. 5. In his opinion, Petitioner is at maximum medical improvement. He is basing that opinion on the records, Petitioner's ability to return to work following the surgery, the minimal MRI findings and lack of correlating findings on examination. RX 1, p. 25. He found Petitioner capable of full duty but indicated she could undergo a functional capacity evaluation if she felt unable to do so. RX 1, p. 26.

Under cross-examination, Dr. Mohan testified he no longer has the treatment records or MRIs. The questions he answered in his report are questions posed by the adjuster, Thomas Broeder. RX 1, p. 28. He did not tailor his examination or records review to the questions. He has no clue how much he charged for his examinations. He charges $2500 for two hours of deposition time. Two hours is the minimum. RX 1, p. 29. When he was at the DuPage Medical Group, he probably performed six IMEs per week. Now he does about six per month. At DuPage Medical, almost 98% of the parties he did examinations for were carriers or defense attorneys. He started his own practice in October 2018. He reviewed the MRI images from December 23, 2017 but did not review the report or images from November 4, 2016. RX 1, p. 35. It was reasonable for Petitioner to undergo three additional epidural injections after April 2017. RX 1, p. 37. Such injections address radicular pain. RX 1, p. 38. In his opinion, the MRI performed in 2017 showed no significant stenosis at any level but there was an area of

foraminal stenosis at L5-S1. If there had been L5 radiculopathy, it would have shown up on the EMG. Instead, the EMG demonstrated S1 radiculopathy. It is possible that the mild stenosis at L5-S1 would be indicative of an L5 nerve root complaint. RX 1, p. 40. He did not review Dr. McNally's note of March 13, 2018, Dr. Barnett's note of March 12, 2018, the repeat MRIs of May 21, 2018 and January 20, 2020 or the repeat EMG. If the repeat EMG showed L5 radiculopathy, "it is most likely caused [by] the L5-S1 level." The last treatment note he reviewed was dated February 1, 2018. RX 1, p. 43. He has no idea of how Petitioner's symptoms changed after that date. In his view, Petitioner's symptoms significantly improved after the decompression surgery. RX 1, p. 44. At the February 2018 examination, he noted no embellishment. Petitioner complained of pain but was able to perform all the functions. RX 1, p. 47. He recommended an EMG after the first examination but Petitioner seemed "very functional" after the second examination. If there were neurological findings on MRI after his second examination and then also findings on the repeat EMG, further treatment, including surgery, potentially, could be warranted. RX 1 at 49. If the EMG changed, "then it would almost be a new incident as opposed to a continuation of the same problem." RX 1, p. 50. However, there is no evidence indicating Petitioner reinjured her low back after the work accident. RX 1, p. 50. He cannot comment on Dr. McNally's recommendations after April 2018 because he has not re-examined Petitioner or seen any treatment records after that period. RX 1, p. 52. Lifting 55-pound bags could cause a lower back injury or aggravate stenosis. RX 1, p. 52. All of the treatment through February 1, 2018 was appropriate. RX 1, p. 53.

On redirect, Dr. Mohan testified that his opinions are in line with the treatment records and his examinations. RX 1, p. 54. He reiterated that Petitioner required no additional care as of his re-examination but went on to say that a functional capacity evaluation could be performed. RX 1, p. 54. He found Petitioner capable of full duty since radicular symptoms were not evident on examination. RX 1, p. 54.

Under re-cross, Dr. Mohan testified that he based his opinions solely on records generated through February 1, 2018. He did not have the benefit of reviewing the updated records, MRI reports and EMG/NCV results. Any new information would be pertinent in making a judgment in Petitioner's case. RX 1, p. 56.

Petitioner testified she has not undergone the recommended fusion due to lack of authorization. She has continued seeing Dr. McNally. She last saw the doctor on June 21, 2021, at which point he again recommended the fusion. She has continued performing full duty but her symptoms affect her ability to work. As the workday progresses, her pain increases and she begins limping. Her lower back pain radiates to her leg and her foot becomes numb. She also experiences tingling in her lower leg. After she gets home from work, she rests and sometimes cries due to her pain. She has not reinjured her back since the work accident. She used to walk, bike, visit museums and go dancing with her husband but no longer engages in these activities. She has pain when she is on her feet. She has difficulty lifting her grandchildren. She still wants to undergo the fusion because she wants her life back.

Under cross-examination, Petitioner testified that Respondent is accommodating her restrictions. She is able to perform her assigned duties but is in pain all the time. Before the work accident, she experienced a little low back pain but the pain would go away when she rested. After the accident, the pain was constant. Before the accident, she was able to walk, dance and engage in other recreational activities. She did not seek care on the date of the accident. Her shift was nearly over when she was injured and, at that point, she felt she would get better. She had Saturday and Sunday off. She worked approximately five days before she sought care. Dr. Novoseletsky diagnosed her with degenerative joint disease. She understands what this is but does not know how to explain it. She did not know that this is part of the aging process. She does not recall Dr. McNally telling her in June 2016 that there was no guarantee a fusion would work. She does not recall reporting minimal leg symptoms in February 2017, following surgery. She experiences different levels of pain each day. After Dr. McNally released her, Respondent provided her with full duty. At this point, she had stepped down from her managerial position and was performing a lighter inventory control job. She still has to perform lifting in inventory control but she gets help as needed and stays within her restrictions. Dr. McNally advised her not to have a spinal cord stimulator inserted. He told her this would not cure her and it would simply alleviate her symptoms. Dr. McNally told her that a fusion was a better option than a revision discectomy. He also told her a fusion would result in scar tissue. He did not tell her that a fusion has unpredictable results. She is aware that, when Dr. Mohan examined her, he felt her subjective complaints did not line up with the objective findings. She felt that Dr. Mohan did not really understand her situation.

On redirect, Petitioner testified that her injury occurred on New Year's Eve and that she had a couple of days off afterward. Respondent did not question the accident. Respondent authorized and paid for her post-operative care. Before the accident, she experienced symptoms on an occasional basis. She did not seek any back care until after the work accident. She is not an orthopedic surgeon. She relies on her physicians for advice. Dr. McNally recommended one kind of surgery in the past and she agreed. He is now recommending a different type of surgery. Her current inventory control job is less physically demanding than her previous job. She believes she would have difficulty performing her previous job. When Dr. McNally released her to full duty, he told her to return to him in two months. When she returned at that time, she had symptoms. She understands that no surgery can guarantee results. She still wants to undergo the recommended fusion.

Under re-cross, Petitioner testified she does not recall Dr. McNally telling her in 2016 that she was not a candidate for a fusion. She understands that a fusion is a riskier procedure. She still wants to proceed.

On further redirect, Petitioner testified she remained symptomatic after the October 2016 decompressive surgery.

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working individual who simply wants to try to get better. Dr. McNally, a surgeon selected by the company clinic, testified that he has treated Petitioner over a six-year period and finds her believable. PX 5, p. 58. The Arbitrator, like Dr. McNally, concludes that the fact Petitioner has continued working, despite her back pain, is a testament to her diligence rather than an indication that she does not require more surgery. PX 5, p. 50. Respondent's examiner, Dr. Mohan, did not find any indication of symptom magnification, although he did note some inconsistencies between Petitioner's complaints and his examination findings.

Overall, the Arbitrator found Petitioner very credible.

The Arbitrator finds Dr. McNally more persuasive than Dr. Mohan insofar as treatment recommendations are concerned. Dr. McNally has seen Petitioner on multiple occasions over a six-year period while Dr. Mohan has seen her twice. Dr. McNally's treatment is ongoing while Dr. Mohan last saw Petitioner in April 2018, more than three years before the hearing. At his deposition, Dr. Mohan admitted that the last treatment note he reviewed was dated February 1, 2018. RX 1, p. 55. While he knew that Dr. McNally had recommended a fusion, he was unaware of the more recent MRI and EMG/NCV results. He also assumed that Dr. McNally had continued to find Petitioner capable of full duty while in fact the doctor imposed various restrictions in November 2020.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established a causal relationship between the undisputed work accident of December 31, 2014 and her current lumbar spine condition of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident lumbar spine treatment; 2) the fact that none of the records in evidence document pre-accident lumbar spine treatment; 3) Petitioner's credible testimony concerning the mechanics of the accident and the abrupt onset of symptoms; 4) Dr. McNally's testimony that the accident aggravated Petitioner's underlying degenerative condition; and 5) Dr. Mohan's concession that the accident "aggravate[ed] a pre-existing, progressively deteriorating condition beyond normal progression" [Mohan Dep Exh 2, p. 5].

The Arbitrator further finds that Petitioner established causation as to the need for the anterior fusion recommended by Dr. McNally. In so finding, the Arbitrator relies primarily on Dr. McNally's testimony that both the accident and the first surgery (which Dr. Mohan characterized as reasonable and necessary, Mohan Dep Exh 3, p. 4) contributed to the need for the fusion. He cogently explained that a patient can develop contralateral leg symptoms after an initial back surgery and that those symptoms can bring about the need for more surgery. Under Illinois law, a claimant need only establish that a work accident is a cause of his or her condition. A claimant is not required to eliminate all other possible contributing causes. Sisbro,

Inc. v. Industrial Commission, 207 Ill.2d 193 (2003). The Arbitrator also notes there is no evidence of any reinjury or other intervening event that would sever the chain of causation.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses from Alexian Brothers (Amita) Medical Group, Suburban Orthopaedics and Chicago Pain and Wellness Institute. PX 6. Respondent disputes this claim.

The first claimed bill, from Amita Health Medical Group, relates to Petitioner's initial treatment from January 8, 2015 through March 27, 2015. The bill reflects charges totaling $5,197.00, various payments (by Gallagher Bassett) and adjustments and a zero balance. The Arbitrator finds the treatment rendered at Amita Health to be reasonable and necessary, as well as causally related to the work accident. Amita (a/k/a Alexian Brothers) was a provider of Respondent's, not Petitioner's, selection. Respondent's examiner, Dr. Mohan, acknowledged that all of the treatment through February 1, 2018 was appropriate. The bill appears to have been paid in full.

The second claimed bill, from Suburban Orthopaedics, relates to treatment rendered by Drs. McNally and Novoseletsky as well as physical therapy and work conditioning. With the exception of certain 2020 and 2021 charges for treatment of plantar fasciitis and/or other foot problems, including January 2021 charges for foot X-rays and excision of a lesion from a tendon (on January 6, 2021), the Arbitrator finds the treatment to be causally related to the work accident. Petitioner did not testify to having plantar fasciitis or an excision procedure and Dr. McNally's deposition predated this care. There is no evidence supporting the conclusion that the work accident of December 31, 2014 brought about the need for plantar fasciitis treatment and tendon sheath excision surgery years later.

The bills from Chicago Pain and Wellness Institute relate to the three lumbar injections that Dr. Belmonte administered in July, August and September 2017. Two of the bills have been paid in full and the third appears to reflect a credit or overpayment of $94.75. The Arbitrator finds these injections to be causally related to the work accident as well as reasonable and necessary. Respondent's examiner, Dr. Mohan, testified that the injections were appropriate.

Is Petitioner entitled to prospective surgery?

The Arbitrator finds that Petitioner established causation as to the need for the recommended anterior lumbar fusion. The Arbitrator also finds that the fusion is reasonable and necessary. In so finding, the Arbitrator relies on the opinions of Dr. McNally, again noting that this physician was a referral from the company clinic. During his deposition, Dr. McNally opined that the work accident aggravated Petitioner's underlying degenerative disc disease, bringing about the need for the initial laminotomy, and that, unfortunately, bilateral symptoms can develop after such a surgery. He further opined that a combination of factors, including the

work accident and laminotomy, brought about the need for the anterior fusion that he initially recommended several years before the hearing. Although Respondent's examiner, Dr. Mohan, initially opined that Petitioner was at maximum medical improvement as of his 2018 re-examination, he conceded under cross-examination that he reviewed no treatment records after that re-examination and that Petitioner could be a candidate for additional surgery if repeat studies showed neurological abnormalities. He admitted that he was unaware of the repeat EMG/NCV which was suggestive of L5 radiculopathy.

As for the reasonableness and necessity of the proposed fusion, Petitioner has truly exhausted conservative care. She underwent therapy and additional injections after the 2016 surgery yet remained symptomatic. She is functional in the sense that she can perform the limited physical duties required of her current inventory control position but credibly testified she has to avoid recreational activities so as to preserve her energy for work. She has had a long time to think about the proposed fusion and accepts that it is not without risks. The Arbitrator finds her to be an appropriate candidate for the fusion that Dr. McNally has recommended.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC022194
Case Name	RIGGLE, TYLER v. GUARDIAN WEST
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0126
Number of Pages of Decision	27
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Patrick Hanlon
Respondent Attorney	John Sturmanis

DATE FILED: 4/6/2022

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TYLER RIGGLE,

Petitioner,

vs. NO: 19 WC 22194

GUARDIAN WEST,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, and vocational rehabilitation and maintenance, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, vocational rehabilitation and compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT

Petitioner was a 28-year-old receiving clerk employed by Respondent unloading steel coils on June 27, 2019, when a steel coil weighing 13,600 lbs. fell on him and pinned him. As a result of this work accident Petitioner suffered an above the knee amputation of his right leg, a crush injury of his left heel requiring skin grafts, and a right ulnar fracture with severed tendons.

Petitioner testified at hearing that he remains under treatment with his orthopedic surgeon Dr. Benjamin Stevens, and his prosthetist Tracy Melton. He continues to receive physical

therapy on a weekly basis for balance issues. He has been fully restricted from work since the time of the accident. Petitioner testified that it is his understanding that he will not be released to return to work until his right leg prosthesis fits and functions well. Petitioner graduated from high school but has no further education or vocational training. He is single with no children and resides with his father and grandmother.

The medical evidence adduced at trial shows that Mr. Riggle underwent a right leg amputation on June 27, 2019, followed by two additional surgical revisions of the stump through July 29, 2019. He was also diagnosed with open fractures of the left tibia and calcaneus that required surgical irrigation and debridement. After Petitioner was stabilized medically, he underwent an open reduction and internal fixation of his right ulnar fracture.

On August 2, 2019, Petitioner's underwent a right transforaminal leg amputation due to failure of the previous below the knee amputation. Also on that date, Dr. Neumeister performed an excisional debridement of the skin, subcutaneous tissue and extensor tendons from Petitioner's left dorsal ankle. A split thickness skin graft was performed using tissue from Petitioner's left thigh. Petitioner was discharged from Memorial Medical Center on August 9, 2019.

Petitioner was admitted to Shirley Ryan AbilityLab on August 30, 2019, for a course of comprehensive inpatient rehabilitation from his multiple injuries. At the time of discharge on September 21, 2019, Petitioner still required supervision for shower transfer and bathing. He was confined to a motorized wheelchair pending healing of his right stump sufficient to accommodate a prosthetic leg.

On January 10, 2020, Petitioner had an initial consultation with Hanger Clinic for prosthetic fitting. A "test socket" was provided on February 27, 2020. Petitioner received his prosthesis from Hanger on March 20, 2020. Petitioner received multiple adjustments but did not achieve a stable fitting socket. On May 19, 2020, Petitioner was utilizing 14 plies of socks, with a number of pads but still did not have a stable fitting prosthesis. His last appointment with Hanger was on June 1, 2020, at which time he reported problems with his prosthetic foot turning, poor fit, and instability.

Petitioner consulted Comprehensive Orthotics and Prosthetics on December 8, 2020. He began the process of developing molds for a new prosthetic socket with vacuum suspension. After a series of repeated modifications and recalibration of the knee joint the new prosthetic leg was delivered on March 24, 2021. It was noted in the chart that Petitioner was scheduled to begin physical therapy on March 25, 2021.

On March 1, 2021, Respondent had Petitioner examined by Dr. Nogalski pursuant to Section 12 of the Act. Petitioner reported that his stump was still decreasing in size and had not yet matured completely. Dr.Nogalski commented in his report that Petitioner was still undergoing prosthetic optimization. On physical examination Petitioner ambulated with the

assistance of a single prong cane and was noted to have an unsteady gait with difficulty navigating turns on his foot.

Dr. Nogalski opined that Petitioner did not require further treatment for the injury to his right upper extremity but did acknowledge that he might require fusion of his left ankle should his symptoms remain ongoing. Dr. Nogalski further opined that Mr. Riggle "appears to be at maximum medical/surgical improvement with respect to his current treatment regime". Dr. Nogalski concluded that Petitioner could have returned to light duty sedentary work on August 21, 2020.

Petitioner was last seen by his treating orthopedic surgeon, Dr. Stevens on April 13, 2021. Petitioner presented using a cane to ambulate. He reported that the warmer weather was causing his socket to slip, and that his socket became uncomfortable after sitting for prolonged periods. Dr. Stevens determined that Mr. Riggle would not achieve MMI until his socket fit comfortably without rubbing or pinching. He ordered Petitioner to remain off work and return to clinic for further follow up in 6 weeks. Dr. Stevens documented in his plan of care that even after Petitioner reaches MMI he may still require additional orthotics, physical therapy, bracing or even further surgery, as the result of his original work injury.

On April 28, 2021, Petitioner was last seen at Comprehensive Prosthetics and Orthotics. He expressed concerns that his toe was dragging. His prosthesis was adjusted and recalibrated. Adjustments were made to the flexible inner socket and Petitioner's ambulation pattern improved. It was noted that he continued to work with physical therapy.

On March 19, 2021, Respondent sent a letter to Mr. Riggle offering light duty sedentary employment at the same plant where he had sustained his injury. Respondent terminated Petitioner's TTD benefits on March 21, 2021. Petitioner did not accept the position and seeks a vocational rehabilitation assessment.

Respondent called John Peeler as a witness to testify at trial. Mr. Peeler is employed by Respondent as the plant manager. He knew Petitioner when he worked at Respondent Guardian. Respondent's business has grown, and they now need someone to input bills of lading every day and reconcile receivers. Currently Respondent is paying two employees overtime to do the data input.

Mr. Peeler testified that Respondent does not have a written job description for the job they have offered to Petitioner. The position is still "evolving" in terms of what Respondent needs done and what skills are needed to perform the job. Petitioner would be working in an area around forklifts. According to Mr. Peeler the job offered to Petitioner would be permanent. The position would pay $17.75 per hour effective June 2022. The job would involve no lifting. Petitioner would be required to walk 5-10 minutes per hour but not every hour. Mr. Peeler acknowledged that the position has not been posted anywhere and has not been offered to anyone

outside to plant. He testified that Mr. Riggle was a good employee who was well liked by his co-workers.

On redirect examination Mr. Peeler testified that COVID has increased the need for the position that is being created for Petitioner. According to the witness the need is not temporary because of COVID.

Petitioner presented Steven M. Blumenthal, a certified vocational rehabilitation counselor to testify in support of his Petition for Vocational Rehabilitation benefits filed pursuant to Section 8(a) and Rule 9110.10. Mr. Blumenthal testified to his education, qualifications, and experience in the field of vocational rehabilitation. He testified that the whole purpose of vocational rehabilitation is to provide the individual, consistent with their physical and intellectual abilities and training, the ability to perform work for identifiable full-time job descriptions that would exist, not only with a specific employer, but with other employers in his geographic area that he would be able to access.

Mr. Blumenthal testified that he was contacted by Petitioner's attorney and completed a vocational rehabilitation interview with Mr. Riggle via Zoom. He reviewed the medical records of Dr. Stevens, Hangar Clinic, and Comprehensive Prosthetics.

During the interview Petitioner told Mr. Blumenthal that he graduated from high school in 2010. His grades ranged from A to C. He was in special education classes and had a diagnosis of ADD/HD and he had an Individualized Educational Plan. He did not participate in any post-high school education. Petitioner has been employed by Respondent since 2015. Petitioner was employed by Caterpillar as an order picker from 2012-2015. He previously worked for Solo Cup as a material handler.

Mr. Blumenthal has not completed a transferable skills analysis at this time as Petitioner has not been released to work by any physician with a documented medical foundation of his ability to stand, walk, carry, or lift. The physician develops the medical foundation for what the Petitioner can perform physically which is the predicate for the transferable skills analysis.

Mr. Blumenthal opines that Petitioner is not currently able to perform any job that he has performed in the past. He is a candidate for vocational evaluation testing which would involve assessing his achievement skills, aptitudes, and interests to determine if he would be a candidate for various types of training. At present vocational job placement would be premature.

Mr. Blumenthal testified that Petitioner needs a complete vocational evaluation before other steps in the vocational rehabilitation process can be considered. He requires vocational evaluation testing.

Mr. Blumenthal expressed several concerns about the job offer Respondent has extended to Petitioner. The job offer contains no job description other than the job is described as light

duty work by Respondent. Petitioner's current physical abilities do not qualify him for light duty work per the U.S. Dept of Labor definitional criteria. The letter containing the job offer references clerical work, but clerical is a generic term. Petitioner needs specific duties that he can perform from both a physical and intellectual standpoint.

According to Mr. Blumenthal, Petitioner does not need to be at MMI to perform psychometric testing. Petitioner has sustained a loss of job security. He does not have access to a stable labor market at present. Petitioner's loss of job security is the result of his catastrophic injuries. When an individual is unable to return to their regular job activities after completing medical treatment vocational rehabilitation counselors perform interviews, vocational testing, and coordinate job placement assistance as necessary to assist the individual in getting back into the competitive labor market.

CONCLUSIONS OF LAW

The Arbitrator found Mr. Blumenthal not to be a credible witness. He found the opinion expressed by Respondent's Section 12 evaluator Dr. Nogalski that Petitioner was at MMI persuasive and that he could return to the position offered by Respondent. Finally, the Arbitrator made the determination that Petitioner should have accepted and attempted the position offered by Respondent. He denied the Petitioner's request for vocational rehabilitation assessment and terminated TTD benefits effective March 21, 2021.

The Commission views the evidence differently from the Arbitrator and finds that Petitioner is a young man who suffered a catastrophic and life changing injury. He has not been declared at MMI by Dr. Stevens, his treating orthopedic surgeon.

At the time of hearing Petitioner had not been returned to work by Dr.Stevens. He was continuing to require adjustments to his prosthetic leg. He was also still in physical therapy. He continued to rely on a cane for ambulation because of balance issues with the prosthetic leg.

It is undisputed that Petitioner cannot return to his prior employment by virtue of his physical injuries. Petitioner has only a high school diploma. He was diagnosed with ADD/HD and had an Individual Educational Plan in high school. Based upon his employment history it is apparent that Petitioner has always earned his living in significant part by manual labor. It cannot be determined at present what employment Petitioner is suited for considering his work history, education, and physical disability. While he did perform some data input in his prior job, the position offered would require a level of sustained technical ability that has previously not been required of Petitioner.

The Commission is concerned about the specific requirements and stability of the data entry job that Respondent has offered to Petitioner. Respondent's own witness, Mr. Peele, admitted in his testimony that the job offered to Petitioner has no description and continues to "evolve". The glut of data entry work that Mr. Peele described may well be a function of supply

chain delays and the demand for new automobiles that has arisen from COVID. Whether this increased demand by Respondent for data entry will be permanent or is transient remains to be seen as the effects of the pandemic recede.

The Commission finds that Section 8(a) and Rule 9110.10 *mandates* a vocational rehabilitation assessment in this case. It cannot be fairly debated that this young man is entitled the vocational training necessary to succeed and be able to support himself throughout his working life. Petitioner is age 28 years currently he may have 40 more years of work life expectancy taking him to the year 2062.

It does not appear that the Respondent's job offer was made in bad faith. The reality however is that this young man has done physical work primarily and his ability to perform data entry full-time is untested as is his ability to succeed with the technological and physical challenges that his future career will pose.

The statement by the Arbitrator that Petitioner "should have" attempted the job offered is not a finding supported by the evidence. Mr. Blumenthal's point is well taken that Petitioner would benefit from a clear job description and the training he needs to succeed in a competitive labor market. Further, we note that Dr. Stevens has not yet released Petitioner to work in any capacity and Petitioner was still in the process of finding a suitable and well-fitting prosthetic at his most recent visit with Dr. Stevens on April 13, 2021.

The Commission is not persuaded by Dr, Nogalski's opinion that Petitioner was able to return to light duty, sedentary work as of August 2020, and finds that Dr. Nogalski's own findings and the medical records undermine his opinion. The Commission is concerned by the obvious inconsistency between Dr. Nogalski's observations of Petitioner's ambulation on physical examination, expected need for further optimization of his prosthesis, limited ability to use both upper extremities due to his reliance on a cane, need for future left ankle procedure due to ongoing symptoms, and his opinion that Petitioner has reached maximum medical/surgical improvement. Additionally, Respondent's argument that Petitioner was "released" to work or placed at MMI by the certified/licensed prosthetists/orthotists that fitted Petitioner because Petitioner was advised to return as needed and did not make a follow-up appointment immediately is unfounded and unreasonable. The Commission notes that the certified/licensed prosthetist/orthotist did not (and was not in a positto) find that Petitioner had reached MMI and/or could return to work, and the care provided by the certified/licensed prosthetist/orthotist was limited to measuring and fitting the prosthetics recommended by physicians.

The Commission hereby finds based upon the preponderance of the evidence that Petitioner is not at MMI. The Commission hereby reinstates Petitioner's temporary total disability benefits and notes that Dr. Stevens is in the best position to determine when Petitioner has reached MMI.

Further, Petitioner has met the burden of proof on the need for a vocational assessment. The Commission finds that Petitioner cannot return to employment at present. For that reason, a vocational rehabilitation assessment is required under 50 Ill. Adm. Code 9110.10 (a) (2016). The Commission notes that once Petitioner reaches MMI and is enrolled in a certified vocational rehabilitation program, maintenance benefits are appropriate.

For the foregoing reasons the Commission hereby reverses the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 2, 2021, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $507.26 per week for a period of 99 weeks,(commencing June 28, 2019 through May 20, 2021) 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 noted that Respondent has previously paid to Petitioner TTD benefits commencing June 28, 2019, through March 21, 2021, and no further TTD benefits are owing for that period.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide Vocational Rehabilitation and Maintenance benefits pursuant to Section 8(a) of the Act and Rule 9110.10, which specifically includes but is not limited to a written assessment of the course of medical care and vocational rehabilitation required to return Petitioner to employment as prepared by Respondent's vocational rehabilitation counselor in consultation with Petitioner and Petitioner's counsel.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case is 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 request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

April 6, 2022

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/msb

o-2/23/22
44

/s/ *Deborah J. Baker*
Deborah J. Baker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC022194
Case Name	RIGGLE, TYLER v. GUARDIAN WEST
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	18
Decision Issued By	Dennis O'Brien, Arbitrator

Petitioner Attorney	Patrick Hanlon
Respondent Attorney	John Sturmanis

DATE FILED: 8/2/2021

THE INTEREST RATE FOR THE WEEK OF JULY 27, 2021 0.05%

/s/Dennis OBrien, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TYLER RIGGLE
Employee/Petitioner

v.

GUARDIAN WEST
Employer/Respondent

Case # **19** WC **22194**

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 **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Springfield**, on **May 20, 2021**. After reviewing all 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**

FINDINGS

On the date of accident, **June 27, 2019,**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **39,546.00**; the average weekly wage was $**760.50**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**45,847.29** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**45,847.29**.

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

ORDER

Petitioner reached maximum medical improvement as of March 21, 2021 and is entitled to temporary total disability from June 27, 2019 through March 21, 2021, a period of 90 3/7 weeks, and not thereafter.

Respondent's job offer was made in good faith and Petitioner has not met his burden of proving the need for vocational rehabilitation at this time and the request for vocational rehabilitation is denied.

Maintenance benefits are denied.

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

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

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

Signature of Arbitrator **AUGUST 2, 2021**

ICArbDec19(b)

FINDINGS OF FACT:

TESTIMONY AT ARBITRATION

Petitioner

Petitioner testified that on June 27, 2019 he was employed by Respondent as a receiving clerk, working at the receiving dock. Respondent produced bumpers and he would as part of his job duties unload steel coils, which involved a lot of walking around. He said he worked an eight-hour shift, five days per week, and would be on his feet seven of those hours.

Petitioner said he was working on June 27, 2019 when a 13,600 lb. coil of steel fell and pinned him, resulting in a right above the knee amputation, a crushed left heel with skin grafts, and a right arm fracture with severed tendons. He said that as of the date of arbitration he was still regularly being treated medically for those injuries by Dr. Benjamin Stevens, and working with a prosthesist, Tracy Melton. He said he had been restricted from work since the day of the accident. He said it was his understanding from his doctors that he would not be released to go back to work until the prosthetic fit well and worked well.

Petitioner displayed his prosthetic device at arbitration. He said he now used a cane to ambulate and was not able to walk without the cane. He said this prosthetic was not his first prosthetic, having been fitted for his first in March of 2020, fitted by Nick Perrow at Hanger Prosthetics, which he wore for most of 2020. He said that prosthetic was too big, unstable, and required him to wear 18 plies of socks. He said the edema in his stump had reduced during so he had to wear more plies of socks to get a better fit in the socket so it felt more snug. He said since it made him unstable he was prone to falling, and his doctor ordered a negative pressure suction socket, which is what he had as of the date of arbitration. That new device was developed and built by Tracy Melton, who he began working with in December of 2020. He said he was still working with Tracy Melton as of the date of arbitration, having received the final negative suction device in March of 2021. He said he continues to have problems with that negative suction socket, rubbing which occurs when he sits down or stands up, causing skin irritation and sweating which causes problems with stability.

Petitioner said he was still being treated by Dr. Stevens and was receiving physical therapy once per week. He said he is a high school graduate who had not pursued any college degree or vocational training after high school.

On cross-examination Petitioner said his right ulna was broken in this accident. Petitioner said that when taking the stand to testify he was able to stand without his cane and without pain. He said he was not in pain as he was testifying and did not take any pain medications on the date of arbitration, that he only took over-the-counter pain medication, Tylenol, occasionally, if the pain got bad enough. He said that on a good day he could walk for 45 minutes to an hour, while on a bad day it could be 15 to 20 minutes when it got bad. He said the pain medication he took did not impair his thinking. He said he can stand without balance problems but has balance problems with walking, so he uses a cane.

Petitioner said he had not conducted any type of job search. He said that at the time of this accident he had a valid driver's license, though his father would take him to work as he did not feel comfortable driving, he did not like to drive, though he felt he was capable of doing so.

Petitioner testified that his work for Respondent involved computer work, checking and responding to emails as well as some data entry of inventory. He said he worked with bills of lading. He said he understood he had a sedentary job available for him to return to with Respondent.

On redirect examination Petitioner said he was not currently able to drive because of his amputated leg. He said his right arm fracture was to a forearm bone, the ulna, in the area of the wrist.

Petitioner said that in performing data entry he took information from a bill of lading and transferred it to the computer, and that he did this for about three to five minutes.

On recross-examination Petitioner said he chose not to drive prior to this accident. He said the three to five minutes of typing was for each bill of lading, and he entered multiple bills of lading each day.

Steven Blumenthal

Mr. Blumenthal was called as a witness by Petitioner. He testified that he was a vocational rehabilitation counselor with a Bachelor's Degree in psychology and a dual Master's Degree in vocational rehabilitation counseling and vocational evaluation testing. He said he had spent his entire career in the field of vocational rehabilitation as a vocational rehabilitation counselor, a vocational rehabilitation testing specialist, as a vocational supervisor and as a manager overseeing other counselors. He said the last 19 years had been spent performing those duties with Blumenthal and Associates. He said close to 95 percent of his work involved workers involved in workers' compensation cases with the referrals coming between 50/50 and 60/40 from employers and injured workers' attorneys. He said he was a Licensed Clinical Professional Counselor and had been certified as a rehabilitation counselor by a number of organizations.

Mr. Blumenthal said he was asked by Petitioner's attorney to work with Petitioner, and he interviewed Petitioner via Zoom. That interview was to understand how Petitioner was functioning, both physically and emotionally/psychologically. The worker's education and work history was also obtained. He also reviewed a number of documents provided by the attorney, which included medical records and a video conference deposition of Petitioner of December 29, 2020. He thought the health status form of Dr. Stevens, dated October 6, 2020 was the most recent, and noted that in it Dr. Stevens wrote, "the patient is unable to work," and "Tyler is to remain off work until released by physician." He said subsequent office notes of Dr. Stevens, who was treating Petitioner for his left heel injury as well as his right above the knee amputation and his prosthetic care, did not state Petitioner was released to return to work. He noted Petitioner's hand surgeon, Dr. Barry, had found Petitioner to have reached maximum medical improvement. He said Petitioner used a single point cane to ambulate, as well as a wheelchair at night and in the morning to go to the restroom, as well as a walker to transfer from the shower to the wheelchair.

Mr. Blumenthal noted that Petitioner had never been referred for psychiatric, psychological, clinical or counseling care and he appeared to be doing well from that standpoint. He said Petitioner graduated from high

school in 2010 with grades ranging from A to C. Petitioner advised him that he had ADHD and ADD for which he received an Individual Education Program from the school. Petitioner had no post-high school education and a work history as a receiving clerk and as an order picker for multiple employers, which involved using a fork lift and a cart, and as a material handler packaging boxes of lids and cups and placing the boxes on pallets.

Mr. Blumenthal said he had not performed a transferable skills analysis of Petitioner as he felt it was premature to do so as Petitioner had not been released to work in any capacity by his treating physician.

Mr. Blumenthal testified that he was of the opinion that Petitioner was currently unable to perform any job he had performed in the past and was a candidate for vocational evaluation testing to determine if he was a candidate for types of training. He said that since Petitioner had not been released to work in any capacity the only thing that could be done from a vocational rehabilitation standpoint would be completing vocational testing to determine what his options would be based on projected physical abilities with the worst case scenario being limited to sedentary work, the most restrictive of physical demand levels. He said no assessment of employability or earning capacity could be determined until vocational testing was completed and until guidance was received from the treating physician in regard to what type of a work release would be provided. He said vocational testing might not be premature and the results could be applied once it was known what his physical capabilities were going to be. He said that testing was standardized psychometric paper and pencil testing at a desk. He said Petitioner would have to have a release from Dr. Stevens to even undergo this testing.

Mr. Blumenthal said he believed a job offer had been made to Petitioner via Respondent's attorney, but after reviewing the letter from the attorney he noted it did not have a job description, just a description of a light duty job, which he felt was beyond what Petitioner was capable of doing. He said the U.S. Department of Labor defined light work as requiring a person to stand for 5.6 hours in an eight hour day and lifting 20 pounds occasionally and 10 pounds frequently, while sedentary work involved lifting no more than 10 pounds and doing a majority of the work while seated with only limited standing or walking. He noted that Respondent described the work as clerical work, which he felt was a generic term, and not a specific job title.

Mr. Blumenthal said he had considered the tenets of National Tea in giving his opinions, noting that Petitioner could not perform the work he had performed in the past. He said Petitioner did not have the education, training or experience to perform any sedentary job in a stable job market at this time without going through a vocational rehabilitation process. He said Petitioner's loss of job security was based upon his catastrophic injuries.

On cross-examination Mr. Blumenthal said offering Petitioner a job for which he had the physical and intellectual abilities to perform at the same or increased pay he previously had would not negate vocational rehabilitation. When asked to agree that vocational rehabilitation was not needed to get a job within restrictions, that it happened all of the time, Mr. Blumenthal said that was incorrect. He said that he did not know if the National Tea case he had talked about involved an employee whose employer had not offered him a job, and he did not know if the Petitioner in National Tea was at maximum medical improvement..

Mr. Blumenthal said that during his two hour Zoom interview of Petitioner he did not note Petitioner having any intellectual deficits, and he said Petitioner was able to sit for two hours to complete the interview, Petitioner advised him that sitting was not a problem, and there was nothing in the medical records that indicated medication which would impair Petitioner's ability. He said he did not know if Petitioner continued

to have issues with ADHD or ADD as of the date of arbitration as he had not seen any recent psychological testing that would document that. He agreed that he did not note Petitioner having any intellectual barriers in his report.

Mr. Blumenthal said Petitioner was able to send e-mails and perform data entry of inventory into a computer system, and dealing with bills of lading at work, but those were only one aspect of his job, with other aspects which were physical, such as using a forklift, lifting and carrying weight, walking and standing, things he could not do. When asked if Petitioner could perform a job of data entry of inventory into a computer system and do e-mails if released with those restrictions, Dr. Blumenthal repeatedly did not answer the question, instead saying repeatedly that was not a job, it was only one part of the job, it was just a job task, that until he saw a job description delineating all of the duties and requirement, all of the skills and training needed for a job that existed within Human Resources for that employer he felt it was not reasonable to ask him that question.

Mr. Blumenthal repeatedly tried to avoid answering straight-forward questions but when pressed admitted that nothing in the letters from the attorney offering the job indicated the job was temporary.

On redirect examination Mr. Blumenthal said that nothing in the attorney's letters indicated the job was permanent.

John Peeler

Respondent called Mr. Peeler as a witness. He testified that he is employed by Respondent as their plant manager, overseeing the quality and on-time delivery of their product, and the safety of all the associates in the plant. He said he knew Petitioner as he worked in Respondent's receiving department. In that department Petitioner received product, steel, as well as parcels from Fed Ex and UPS, he unloaded trucks using forklifts and an overhead crane and he did clerical work inputting bills of lading in the computer system, balancing inventory and sending e-mails to people advising them their product had arrived and they should come to shipping to pick it up.

Mr. Peeler said that Petitioner was still an employee, that a job had been offered to him and that the offer/job was still available. He explained that the business had grown quite a bit and they needed someone to input all of the bills of lading daily, to reconcile all of the receivers and to send out emails to department managers advising them their product had arrived at the plant. He said that job would accommodate restrictions, as it included no use of the overhead crane, no forklift driving, no picking up of parcels, no unloading of trucks and limited time on his feet or walking. Mr. Peeler said Petitioner had performed the duties of the job involving inputting bills of lading, reconciling inventory, reconciling receivers, filing receivers and sending emails to people in the building in the past. He said two people were currently performing that work by working overtime in addition to their other work, which is why they were separating those duties out.

Mr. Peeler said they had not written up a job description for the job they had offered to Petitioner as it was still evolving in regard to what skills were necessary to do the position. He said manufacturing of automotive parts had increased and their people could not keep up with doing both the unloading as well as the clerical work, so they were separating the clerical work from the unloading.

Mr. Peeler said the job was to be permanent. He said Respondent was ADA compliant. He said an ADA compliant restroom would be within 10 to 12 feet of the exit door of the office and the use of stairs would not be necessary, that Petitioner would enter the plant on the office level, without using stairs, and if he had the need to go upstairs there was an elevator accessible. He noted that Respondent's plant was the size of three-and-a-half football fields wide and five football fields long, and Petitioner's office would be on the exact opposite side of the building from where his accident had occurred, he would not be able to see where the accident had occurred. The salary for the job was $17.50 per hour as of the date of arbitration and would be increasing to $17.75 per hour at the end of June 2021. He noted that the current pay was more than Petitioner was being paid at the time of the accident, for as a continuing employee he had continued to accrue seniority and would get the raises due him during that period of time.

Mr. Peeler said the job being offered did not require lifting in excess of paperwork. He said it was definitely a desk job, in an office with his own desk. He would have to walk five to ten minutes in an hour, but not every hour.

Mr. Peeler said Petitioner was a very good employee, a hard worker, and very diligent. He said he stayed focused and was task driven. He said he got along with Petitioner, and Petitioner got along with everyone in the plant. Mr. Peeler said he wanted Petitioner to return. He said he currently had to pay overtime to the two employees who were performing this work as there was work that had to be performed, there was work in excess of what the two employees working overtime were able to do. He said the job would be full time and there would be opportunities for overtime work.

On cross-examination Mr. Peeler said Respondent's Urbana plant had a Human Resources department headed by Anastasia Floyd. He said that when saying the job was still evolving he meant they wanted Petitioner to come back to work as they thought he was more than capable to perform the work and they were more than willing to do anything he might need to make him able to do that. He said this job would be tailored to Petitioner's specific restrictions and needs. He said that the four shipping and receiving clerks were currently splitting that work and had to add overtime by two of them. Those four have duties with the crane, forklifts, unloading, and shipping and receiving manual labor as well as clerical work as there is not currently anyone in the job to do the clerical work.

Mr. Peeler said the job was not just being offered to him because of his physical limitations, but because the shipping and receiving people were currently backed up and the bills of lading, the receivers, the computer work was backed up and the controller of accounts receivable had to come in as the bills of lading, etc. were piling up and piling up and people wanted to get paid, and that could not occur until the products were properly received, the work was not getting done on time, causing people from other departments to do it, and Respondent to have people work overtime.

Mr. Peeler said the job had not been advertised for someone outside of Respondent to apply for, and he did not know the reason for that, possibly people in Human Resources knew the answer to that.

Mr. Peeler said the job being offered was on the far west corner of the building, the area of the shipping and receiving docks. He said Petitioner was not injured at the shipping and receiving docks, he was injured at the steel receiving dock which was on the opposite end of the plant. He said bumpers were shipped out of the shipping docks and raw materials such as plastics, wiring, lighting, assembly components and Fed Ex, UPS, etc.

were received there. The materials being received and shipped are moved through the plant by forklifts. The only industrial equipment Petitioner would be close to when working this job would be forklifts.

Mr. Peeler said that Petitioner's limited walking would be to get receivers for Fed Ex and UPS from the delivery person and to sign his name. He would have to walk to the main entrance to come in and out of the building and would have to walk to accounts receivable at the end of the shift each day, which would be about 260 feet and two elevator rides round trip. He might have to go to the rest room by the office and the office had a microwave, a refrigerator and a table. He said the main entrance was about 200 feet from the office Petitioner would work in.

Mr. Peeler was asked if the job being offered to Petitioner was devoid of physical demanding components and he said it had no physically demanding components. He said he had not offered this position to anyone else as Respondent was having issues keeping employees in assembly jobs and other jobs in the plant as people coming back to work from the pandemic were having issues with childcare and school closings and would come to work via a temp agency, work a day, and then leave. They were having trouble filling positions in the plant. He said they advertised for the assembly positions to get people outside the plant to apply, but they had not done so for the position offered to Petitioner, it was not a position open to the general public.

On redirect examination Mr. Peeler said that they did not advertise for all of their jobs. He said COVID had changed things and they were having lots of product being received, more stock was being handled.

Mr. Peeler said that if Petitioner chose not to return Respondent would have to advertise and fill the position.

On recross examination Mr. Peeler said the product had been piling up ever since they had come back in May of 2020. He said the backup is not a temporary thing because of COVID, though the trouble retraining people and getting enough manpower was due to it. He said once they get past COVID they will still need the clerical position in the receiving department. He said COVID has made them retool or rethink how to staff many positions, and how to divide tasks up to be more efficient with less people and this change will get things paid and moving.

On redirect examination Mr. Peeler said the need for work had increased since Spring 2020, that was when they had to start paying overtime. He said if Petitioner did not return they would still have to hire someone for the clerical position in receiving, due to the cost of overtime.

On recross examination Mr. Peeler said that the overtime had been paid since May of 2020 but he had not hired anyone yet as he did not want to take the chance he would hire nine people before he found someone who would do the job as well as Petitioner did the job, he was saving it for Petitioner, he would like to have Petitioner doing the job.

On redirect examination Mr. Peeler said that they knew they needed someone to do this job for quite a while, but he wanted someone as good as Petitioner, and if it was not Petitioner, he'd find someone as good as Petitioner. He said he was not just holding the position for Petitioner, though, as they had other positions in the plant to fill and he could not keep people in jobs. He said building and selling bumpers was their business so he had to get workers to make product and the support positions, which did not add value to product, were secondary.

Steven Blumenthal

Mr. Blumenthal was recalled as a witness by Petitioner. He said that the clerical position described by Mr. Peeler was not the same position he was performing when he got injured. He said if there was not a standard human resources job description that prior people had performed then it would be a "make job," not one which would necessarily exist but for the injuries to the worker, or in a stable job market. He said that the job might meet the employer's needs for the moment, but if that person for any reason was unable to continue working with that employer they would not have the requisite skills and abilities to market themselves in the competitive labor market. He said if the Human Resources department had identified, analyzed internally and met company guidelines and then posted and interviewed for the position that would give the job offer more credibility.

On cross-examination Mr. Blumenthal was asked what percentage of employment was done without a specific job description. He did not answer the question as asked but instead testified that every job he had dealt with for injured workers had been based around a job description from the Dictionary of Occupations titles or by employers, but he had no research as to what degree all employers were not using defined job descriptions. When asked again if he knew the percentage he again refused to answer, saying the question was too general and could not be answered. When asked if a job was invalid on its face because it did not have a job description Mr. Blumenthal again did not answer the question directly, but instead talked about components of jobs. When asked the question again he again did not give a yes or no answer but instead said, "If it doesn't have a job description it is not a job, it's a task. It would not be valid."

MEDICAL EVIDENCE

Petitioner was seen immediately after the accident in the emergency room at Carle Foundation Hospital for bilateral crush injuries to the legs, especially the right leg, and an open wound to the dorsal right forearm. Petitioner received care at that facility from June 27, 2019 through July 19, 2019 including a right below the knee guillotine amputation and an irrigation of a left open distal tibia fracture and a left open calcaneus fracture on the date of the accident. He subsequently had complications and a revision right below-knee amputation surgery was performed on June 29, 2019. The amputated leg continued to have problems and a third procedure, a wound exploration, debridement and washout with skin graft placement was performed on July 15, 2019. Petitioner's right arm fracture did not undergo surgery during this hospitalization, and surgery for the left leg fracture was postponed to stabilize Petitioner. Petitioner was transferred to Springfield's Memorial Medical Center for a higher level of care on July 19, 2019. PX 1 p.2,10,12-16

Upon arrival at Memorial Medical Center it was noted that Petitioner was in a short leg splint for his left lower leg pilon fracture, calcaneus fracture and navicular fracture and a volar resting splint had been applied for his right wrist and forearm ulnar fracture. Petitioner's complaints upon admission in regard to his left leg were that his great toe was hypersensitive and he had no sensation in his left little toe. His right wrist/arm complaints were of an inability to extend his right long, ring and little fingers. PX 2 p.2,4

On July 24, 2019 Dr. Stevens performed surgery on Petitioner's left leg, an open reduction and internal fixation of the left calcaneus. PX 2 p.6,7

On July 30, 2019 Petitioner underwent an open reduction and internal fixation of his right ulnar fracture. PX 2 p.11

On August 2, 2019 Dr. Neumeister performed an excisional debridement of skin, subcutaneous tissue, and extensor tendons from Petitioner's left dorsal ankle. A split thickness skin graft was then performed using tissue from the left thigh. PX 2 p.8,9

Also on August 2, 2019 Petitioner underwent a right transfemoral amputation of the right leg due to a failed below the knee amputation. PX 2 p.12

Petitioner was discharged from Memorial Medical Center on August 9, 2019. PX 2 p.12

Petitioner received inpatient therapy from August 30, 2019 through September 21, 2019 at Shirley Ryan AbilityLab in Chicago. The discharge summary for that visit was introduced into evidence. It indicates Petitioner was trained on bed mobility, transfers from standing to sitting and sitting to standing, car transfers, bumping up and down stairs, use of a motorized wheel chair provided by workers' compensation, toilet transfer, shower transfer, and bed to wheelchair transfer. They felt he was appropriate for discharge on September 21, 2019 but should have some supervision for shower transfer and bathing. PX 4 p.2-4

Petitioner consulted with Hanger Clinic in regard to getting a prosthesis, beginning on January 10, 2020, and getting a test socket on February 27, 2020. A prosthesis was delivered to Petitioner by Hanger on March 20, 2020. When seen on May 19, 2020 it was noted that Petitioner was having adjustments made to the socket and was using 14 plies with several pads and a thick pad to snug up the area. Petitioner was last seen at that facility on June 1, 2020 with multiple complaints about the prosthesis including his foot turning. PX5 p. 2,15,16,20,21, 24,25,27

Petitioner then had his prosthetic needs met by Comprehensive Orthotics and Prosthetics commencing on December 8, 2020. At that time Petitioner was in need of a new prosthetic socket with vacuum suspension which would increase his stability. They found Petitioner to have no skin concerns during their evaluation. A cast was made for a diagnostic fabrication. A diagnostic fitting with immediate adjustments was done on January 13, 2021, and a new replacement socket was ordered. On February 24, 2021 another cast was made and it was planned that the orthosis would be delivered and another diagnostic fitting would occur on March 19, 2021. A replacement socket was fit for Petitioner on March 10, 2021, and the socket was modified during this visit and it was sent to the lab for full fabrication. On March 24, 2021 the new socket was placed on his prosthesis, Petitioner was able to ambulate in it and it felt stable during ambulation, with Petitioner describing it as very secure. Petitioner left that appointment wearing the prosthesis with the new socket. Petitioner was last seen on April 28, 2021. Petitioner reported that overall he was doing well with the prosthesis. The knee was calibrated using computer software and was found to be functioning properly and no signs of concern were found. The knee was recalibrated, and Petitioner was seen to be walking with a smoother gait pattern and not having toe drag. PX 6 p.2-7

While it is obvious Petitioner must have been seen by one or more physicians regularly following his discharge from the hospital, no physician records were introduced for the period of August 9, 2019 until October 5, 2020, a period of 14 months.

Petitioner was seen by Dr. Stevens for both leg injuries on October 6, 2020. He was walking with a prosthetic leg and a cane, with some discomfort and pinching by the prosthetic to the back of his right thigh. Petitioner felt the leg was putting him at risk of falling as it was not stable. Petitioner had finished physical therapy as of October 1, 2020. It was felt Petitioner needed a suction stump on his leg and had not yet reached MMI. A Health Status Form of that date states Petitioner was to remain off work until released by a physician. Dr. Stevens wrote a "to whom it may concern" letter on October 16, 2020 noting the old socket on Petitioner's prosthetic leg was quite ill-fitting, and falling off his leg randomly, saying that a new socket was necessary. PX 3 p.2,3,5

Dr. Stevens saw Petitioner on February 9, 2021, and found him to be ambulating with a cane and reporting occasional lateral left ankle pain and occasional pulling and discomfort in his Achilles, for which he took Tylenol. He had recently changed to a new prosthetic supplier, CPO, and was waiting on new parts for his prosthesis to alter it in hopes of mitigating discomfort. The physical examination of Petitioner's right stump and his left leg showed both to be neurovascularly intact with full strength, normal sensation and range of motion as would be expected. Dr. Stevens noted that Petitioner could continue with healing and progress his physical activity as tolerated. Once his prosthesis was altered physical therapy would be ordered to help him with his gait. He said Petitioner would not be at MMI until the prosthetic fit comfortably and then he would, "be labeled disabled, (and) would require a sedentary job." He again issued a Health Status Form saying Petitioner should be excused from work until released by physician. PX 3 p.8,9,11

On March 1, 2021 Respondent had Petitioner examined by Dr. Michael Nogalski pursuant to Section 12 of the Act. At the time of his examination Petitioner was still utilizing the original socket but it was noted that the ultimate plan was for a suction socket to replace it. Petitioner advised him that his right leg was doing well in general, that he had a good, healed stump without any skin breakdown. He said he did have some phantom limb sensations, but no significant phantom leg pain. He advised Dr. Nogalski that he had applied for and received Social Security Disability and had also received Medicare benefits in December of 2020. Dr. Nogalski's physical examination of the right leg stump found a solid distal stump with good skin color and texture, good hip flexion and solid adductor functions. He found adduction strength to be 5-/5. Dr. Nogalski also examined the left wrist and the left leg injuries. He found Petitioner to lack 10 degrees of pronation and supination in the left wrist, as well as slightly diminished grip strength. He found some limitation in range of motion of the left ankle as well as well healed skin grafts over the dorsal and lateral aspects of the left foot and ankle. Dr. Nogalski reviewed numerous medical records. RX 1 p. 1-4

Dr. Nogalski's diagnoses were consistent with Petitioner's treating physicians and the hospital records admitted into evidence. He felt Petitioner's prognosis was good given his current medical condition and he felt Petitioner was at maximum medical improvement with his treatment regimen. He said continued prosthetic optimization was to be expected at this time. He felt Petitioner's medical care had been appropriate. He felt Petitioner was capable of sedentary work as of the time he saw him, with no climbing or squatting, no lifting more than 10 pounds and his using a cane as needed. RX 1 p.4,5

Dr. Stevens's last office note is dated April 13, 2021. Petitioner at that time advised him that his prosthesis was no longer pinching as it had before, was fitting better, but had started slipping because of increased heat outside. He noted he had some concerns about returning to work as he did not feel comfortable sitting in his socket. He said his gait was improving, but he was unable to sit without discomfort after long periods of time. He also noted he had not been cleared to drive as he did not feel comfortable driving with his left foot. Dr. Stevens's physical examination of Petitioner's legs again showed no objective abnormalities other than the obvious amputation. Dr. Stevens said Petitioner would not reach MMI until his prosthetic leg fit comfortably without rubbing, pinching, etc. Dr. Stevens said he gave a renewed off work slip at that time. PX 3 p.12,15

ARBITATOR'S CREDIBILITY ASSESSMENT

Petitioner appeared to be testifying in an honest, straightforward manner. He did not display any exaggeration in his physical condition, he walked to counsel table, the witness chair, and around the hearing room with the aid of a cane, and admitted he was able to stand without his cane and without pain, that he was not in pain as he was testifying and did not take any pain medications on the date of arbitration, only taking over-the-counter pain medication, Tylenol, occasionally. Petitioner seemed to answer all questions put to him. **The Arbitrator finds Petitioner to be a credible witness.**

Mr. Blumenthal seemed more a biased advocate for Petitioner than an impartial witness. He repeatedly refused to answer straightforward questions to him on cross-examination and he appeared to view everything Respondent was trying to do to provide Petitioner with an accommodated job with suspicion, basically accusing Respondent of acting in bad faith in creating a make work position for Petitioner. Mr. Blumenthal appeared to be a very well qualified, experienced vocational rehabilitation counselor, but he was quite willing to testify to opinions outside his expertise, to what Human Resource directors do, for instance, when neither his testimony nor his CV indicate any training, experience or expertise in human resources, drafting or timing of job descriptions, or the realities of human resource work during a pandemic when Respondent was having an extremely difficult time keeping sufficient production staff. **The Arbitrator finds Mr. Blumenthal on this occasion to not be a credible witness.**

Mr. Peeler answered all questions in a forthright manner. He did not appear to attempt to avoid answering any questions, as Mr. Blumenthal had, but on one or two occasions said he did not know an answer for sure, and did not want to mistakenly give an erroneous answer, responses which were accepted by the questioning attorney. He appeared to be genuinely wanting to provide a permanent job to Petitioner which he knew Petitioner was capable of performing as it was entirely tasks he had previously performed successfully. He seemed to be sincerely interested in Petitioner's physical and employment best interest. His explanation of why they created the position offered to Petitioner and the entirely sedentary nature of the position appeared to be honest. **The Arbitrator finds Mr. Peeler to be a credible witness.**

CONCLUSIONS OF LAW:

In support of the Arbitrator's decision relating to what temporary benefits Petitioner is entitled to as a result of the accident of June 27, 2019, the Arbitrator makes the following findings:

The findings of fact, and assessments of credibility, above, are incorporated herein.

The summaries of medical evidence, above, are incorporated herein.

A claimant is entitled to TTD benefits from the time an injury incapacitates him or her from work until such time as the claimant has recovered or been restored to the permanent character that the injuries will permit. "Among the factors to be considered in determining whether a claimant has reached maximum medical improvement include a release to return to work, with restrictions or otherwise, and medical testimony or evidence concerning claimant's injury, the extent thereof, the prognosis, and whether the injury has stabilized.(citation omitted) Once an injured claimant has reached maximum medical improvement, the condition is no longer temporary and entitlement to TTD benefits ceases even though the claimant may thereafter be entitled to receive permanent total or partial disability benefits. When a court determines the duration of TTD, the only questions that need to be asked and answered are whether the claimant has yet reached maximum medical improvement and, if so, when." Freeman United Coal Mining Co. vs. Industrial Commission, 318 Ill.App.3d 170,178 (2000).

According to Petitioner's treating physician, Benjamin Stevens, Petitioner will be at sedentary restrictions after he places him at MMI. According to Dr. Stevens. Petitioner's only remaining treatment is the final adjustment of the prosthetic cup. However, Dr. Stevens also noted that even after Petitioner had reached MMI there continued to be a possible need for prosthetic adjustments. (PX 3 p. 8,9)

Dr. Stevens last saw Petitioner on April 13, 2021 and at that time Petitioner advised him that the prosthetic was fitting better and was no longer pinching as it had before. He noted that Petitioner was concerned about returning to work and told him that he was uncomfortable while sitting. At arbitration Petitioner did not testify to having any difficulty while sitting and sat for an extended period of time with no complaints. Dr. Stevens indicated he was off work, but encouraged Petitioner to continue to exercise regularly to stay in shape. Dr. Stevens did not provide any explanation why Petitioner could not currently perform sedentary work. He said he was labeling Petitioner disabled "due to the difficulties he would encounter in a regular work day." There is no indication that Dr. Stevens had been told by Petitioner or had otherwise been made aware of the restrictions issued by Dr. Nogalski and passed on to Petitioner's counsel by letter from Respondent's counsel of March 19, 2021, or of the light duty work offered to Petitioner in that same correspondence or Petitioner. Nor did Dr. Stevens's records reflect his being aware of the March 25, 2021 letter to Petitioner's attorney from Respondent's attorney where it was noted that Respondent had clerical work in the shipping department available within Petitioner's sedentary restrictions with pay equal to or exceeding Petitioner's pay at the time of this accident. (PX 3, p.12; PX 10; RX 4)

The Hanger Clinic records reflect that on January 24, 2020 Petitioner was described as "a young man who enjoys going out to sporting events which require walking in crowds walking up and down stairs and ramps, walking on uneven surfaces and walking with variable cadence. He also works around the house doing ADL's and helping with yardwork and other chores. He is independent with ADL's. He can drive." Dr. Stevens, however, noted that after Petitioner told him that he had concerns regarding returning to work, he also said that he had not been cleared to drive, as he did not feel comfortable driving with his left foot. This statement would appear to be a statement intended to sway Dr. Stevens's decision in regard to work status, as shown by the prior history to Hanger Clinic and by Petitioner's later testimony at arbitration where he stated he did not drive to work prior to the date of this accident, his father drove him, as he did not feel comfortable driving. The records of Dr. Stevens certainly don't reflect his being aware that Petitioner did not feel comfortable driving to work prior to the accident. (PX 4. p. 6; PX 3 p.12)

Petitioner began seeing Comprehensive Prosthetics and Orthotics (CPO) on December 8, 2020. The first appointment for the fitting and replacement of the cup took place on January 13, 2021. Petitioner expressed satisfaction with the fitting. His final fitting took place on March 24, 2021, and Petitioner noted that the prothesis "was very secure on him and he (was) quite satisfied". The final appointment at CPO was on April 28, 2021, when, after some adjustments, Petitioner said he felt more confident. The same note indicates that the patient declined to schedule a follow up appointment. (PX 4, p. 6,7)

Dr. Nogalski, an orthopedic surgeon, performed a Section 12 examination at the Respondent's request on March 21, 2021. (Rx 4) In his report Dr. Nogalski opined that Petitioner had reached MMI and was able to perform sedentary work under 10 pounds of lifting. (RX. 1, p.5)

The Arbitrator finds that Petitioner had reached maximum medical improvement as of March 21, 2021 and that Petitioner is entitled to temporary total disability from June 27, 2019 through March 21, 2021, a period of 90 3/7 weeks, and not thereafter. This finding is based upon the physical examination findings, but not restriction opinions, of Dr. Stevens, and the physical examination and opinions of Dr. Nogalski. Dr. Nogalski's opinions on maximum medical improvement appear to be supported by the objective medical record findings admitted into evidence. While Petitioner may need occasion adjustments to his prosthesis and possibly occasional physical therapy, as well as ongoing observation by his treating physician, additional improvement does not appear likely. In addition, Petitioner was offered work within his physical restrictions as set out by Dr. Nogalski, sedentary work which would primarily be performed at a desk with minimal walking in the plant or in entering or exiting the workplace. This is also consistent with the Arbitrator's observations at arbitration, where Petitioner walked without difficulty while using a cane, stood without the use of a cane, showing no balance issues or pain, and voiced no complaints of pain during the proceeding.

In support of the Arbitrator's decision relating to whether Petitioner is entitled to vocational rehabilitation and maintenance benefits, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence, above, are incorporated herein.

The findings relating to temporary total disability, above, are incorporated herein.

Section 8(a) of the Act (820 ILCS 305/8(a)) states that an employer "shall *** pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto."

VOCATIONAL REHABILITATION

A claimant is generally entitled to vocational rehabilitation where a work-related injury has caused a reduction in earning capacity and there is evidence that rehabilitation will increase earning capacity. Greaney v. Industrial Commission, 358 Ill.App.3d 1002, 1019 (2005). If a claimant has skills and abilities sufficient to obtain employment without further training or education, an award of vocational rehabilitation is not necessary. National Tea Co. v. Industrial Commission, 97 Ill.2d 424, 432 (1983).

An injured employee is generally not entitled to vocational rehabilitation where the evidence shows that he or she does not intend to return to work, although able to do so. Euclid Beverage v. Illinois Workers' Compensation Commission, 2019 IL App (2d) 180090WC. ¶30. Vocational rehabilitative services are not mandatory unless the claimant can establish that rehabilitation is appropriate. Euclid Beverage, 2019 IL App (2d) 180090, ¶31. Petitioner has the burden of proving necessity for the rehabilitation. Hunter Corp. v. Industrial Commission, 97 Ill.2d 424 (1983).

At arbitration Mr. Blumenthal testified that formal vocational rehabilitation was pre-mature. As such, he did not examine the need for vocational rehabilitation in the context of National Tea. Mr. Blumenthal repeatedly said that he did not have sufficient information to do a meaningful testing analysis as he would be using projected abilities of Petitioner as the treating physician had not provided actual limitations/restrictions for Petitioner. Mr. Blumenthal specifically indicated that he did not examine requirements of earnings and skills transferability in regard to Petitioner.

As an alternative to formal vocational rehabilitation, Mr. Blumenthal recommended a bifurcated vocational evaluation as it applies to Petitioner's intellectual abilities, but not his physical capabilities. The Arbitrator cannot find any compelling reasons for a bifurcated vocational evaluation. A mental only vocational evaluation is on its face incomplete, there is nothing in the Act that allows for such bifurcation, and a vocational interview was previously performed. Further, as noted by Mr. Blumenthal, Dr. Stevens had not issued actual limitations or restrictions for Petitioner, and it would be speculation or conjecture as to when or if that would occur, and under some circumstances that would make the effort an entire waste as unnecessary or impractical due to the passage of time between the evaluation and the theoretical issuance of final limitations, and any results of such an evaluation would be speculative as of the time it was completed. Performing a vocational test or evaluation which cannot be used in making decisions for an unknown period of time, if ever, does not in any way aid in determining whether vocational rehabilitation costs are reasonable, especially when an accommodated job at Petitioner's prior wage, with raises which had accrued since the date of this accident, has been offered. The only apparent reason to have the bifurcated vocational evaluation would be an effort to qualify Petitioner for ongoing maintenance for an unknown period of time. The evidence establishes that Respondent offered a sedentary job with equal or greater pay than that earned at the time of the accident on March 19, 2021 and on March 25, 2021. (PX 10; RX 4)

Mr. Blumenthal opined that Respondent's job offer was invalid, primarily because there is was no written job description. Neither the Act nor case law require a written job description for the work to be valid. The facts as testified to by Petitioner in noting he had previously performed the work to be performed in this job, the credible testimony of Mr. Peeler in describing this job, the need for an employee to perform this job so it did not have to be performed as an overtime task by people from other departments, his assessment that Petitioner was a very good, diligent employee who performed this work well and his stating the job was permanent in nature, all indicate that this was a valid job offer of a position performing necessary, valuable work for the Respondent, work which was already being performed, with difficulty, by other employees who would be freed up to do their regularly assigned work if Petitioner were performing the offered job..

Mr. Blumenthal's opinions in this regard are not accepted by the Arbitrator. Mr. Blumenthal testified that a position without a prior written job description which had previously been performed by employees would be a "make job," not one which would necessarily exist but for the injury to the worker or in a stable job market. Mr. Peeler testified at length about difficulties Respondent was having as a result of COVID maintaining a workforce to manufacture automotive parts. He said some employees would be hired, work a day and then cease working due to childcare or school closing issues. The fact that Human Resources did not necessarily have the time to analyze a position and draft a job description under such circumstances does not equate to the job offer not being valid. Mr. Peeler seemed quite sincere in his praise of Petitioner as an employee and his wishing to have a known good employee perform this important work rather than try repeatedly to hire someone who might or might not perform the job well or simply walk away from it. The Arbitrator also chooses to give Mr. Blumenthal's opinions little to no weight based upon his appearing to be an advocate for Petitioner rather than a witness honestly answering question from the parties in a truthful, unbiased manner. Mr. Blumenthal refused to answer straightforward questions during cross-examination. He also made statements which had no medical basis, saying that Petitioner could not perform any job he had performed in the past. Petitioner had performed the work he was being asked to perform in the past, while in the past also performing laboring work which had been eliminated from the job he was being asked to perform. He had done this work, and there is no medical evidence indicating he cannot perform a sedentary job. The offered job meets the U.S. Department of Labor's definition of a sedentary job, as testified to by Mr. Blumenthal, as it involves very limited walking, is performed primarily while seated, and does not require lifting greater than ten pounds. This job also met the restrictions set out by Dr. Nogalski.

The job offered to Petitioner will be of benefit to both parties. The offered job will increase plant efficiencies and save overtime expenses currently paid to other employees. The Respondent will also get the benefit of a known diligent and hardworking employee. Petitioner will have a job within his physical abilities that pays him as much or more than he previously was earning

Mr. Blumenthal opined that Petitioner did not have the education, training or experience to perform any sedentary job in a stable job market without vocational rehabilitation. The position offered to Petitioner by Respondent is just such a job, Petitioner has sufficient and training to perform the job as he had previously performed these job tasks, he now would be performing them on a full-time basis. No vocational rehabilitation is necessary to obtain this job.

The Arbitrator finds that the employer's job offer was made in good faith, that Petitioner should have attempted the Respondent's sedentary work offer, and that Petitioner has not met his burden of proving the need for vocational rehabilitation now and the request for vocational rehabilitation is denied. This finding is based upon the facts and analysis stated above.

MAINTENANCE:

Maintenance is awarded incidental to vocational rehabilitation, an employer is obligated to pay maintenance only "while a claimant is engaged in a prescribed vocational-rehabilitation program." Euclid Beverage v. Illinois Workers' Compensation Commission, 2019 IL App (2d) 180090WC. ¶29, quoting W.B. Olson, Inc. v. Illinois Workers' Compensation Commission, 2012 IL App (1st) 113129, ¶39.

The Arbitrator finds that maintenance benefits are denied. This finding is based upon the denial of vocational rehabilitation benefits, above.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC036426
Case Name	ALONZO, SIMEON v. FLEXICORPS, INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0127
Number of Pages of Decision	12
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Jordan Browen
Respondent Attorney	Torrie Poplin

DATE FILED: 4/6/2022

/s/ Deborah Baker, 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

SIMEON ALONZO,

Petitioner,

vs. NO: 19 WC 36426

FLEXICORPS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of whether Petitioner's current condition of ill-being is causally related to his work injury, entitlement to Temporary Total Disability benefits, and entitlement to incurred medical expenses as well as prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 9, 2021 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $386.67 per week for a period of 18 6/7 weeks, representing December 11, 2019 through April 20, 2020, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary, and causally related medical expenses detailed in Petitioner's Exhibit 3 and Petitioner's Exhibit 4, as provided in §8(a), 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 shall provide and pay for treatment recommended by Dr. Levi as provided in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,700.00. 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.

April 6, 2022

/s/ *Deborah J. Baker*

DJB/lyc

O: 3/30/22

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/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

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

ALONZO, SIMEON
Employee/Petitioner

Case# **19WC036426**

FLEXICORPS INC
Employer/Respondent

On 3/9/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5755 COSTA IVONE LLC
JORDAN BROWEN
311 N ABERDEEN ST SUITE 100 B
CHICAGO, IL 60607

4866 KNELL O'CONNOR DANIELEWICZ
TORRIE N POPLIN
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Simeon Alonzo
Employee/Petitioner

v.

FlexiCorps, Inc.
Employer/Respondent

Case # 19 WC 036426

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 of the Commission, in the city of Chicago, on September 30, 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. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On the date of accident, October 24, 2019 , Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $30,160.00; the average weekly wage was $580.00.

On the date of accident, Petitioner was 49 years of age, married, with 1 dependent child.

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

Respondent shall be given a credit of $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 the sum of $7,291.47, representing 18 6/7 weeks at the rate of $386.67 per week, for TTD benefits as outlined in Section L of Arbitrator's Conclusions of Law.

Respondent shall pay directly to Petitioner all medical bills as outlined in Section J of Arbitrator's Conclusions of Law and pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any amount(s) previously paid.

Respondent shall authorize the procedure recommended by Dr. Levi, as well as all post-operative care as outlined in Section K of Arbitrator's Conclusions of Law.

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

3/4/2021
Date

MAR 9 - 2021

FINDINGS OF FACT

Petitioner, Simeon Alonzo ("Petitioner"), was an employee for the Respondent, Flexicorp, Inc. ("Respondent") on October 24, 2019. (Arb. Ex. 1). Petitioner's duties required him to setup die machines which he and another employee operated. (Transcript of Proceedings on Arbitration dated September 29, 2020 "Trans" at 9-10). On October 24, 2019, Petitioner was working on his shift for Respondent when a supervisor called him to assist in unjamming a stuck die machine. (Id. at 10). Petitioner utilized various metal bars to remove a metal bar that had been stuck in the machine. (Id.). When it became unstuck, Petitioner had to remove the other bars he had just inserted, and while doing so, the machine crushed Petitioner's left thumb. (Id. at 10-11).

Petitioner was immediately taken by representatives of Respondent to Loyola Hospital. (Id. at 11). After undergoing medical imaging, he was diagnosed with acute nondisplaced fractures of the distal phalanx of the left thumb and a small avulsion fracture at the tip of the distal phalanx of the left thumb. (Pet. Ex. 1 at 26). The small avulsion fracture was noted at the base of the distal phalanx with the avulsed bone fragment overlying the DIP posteriorly. (Id.). Petitioner was administered Ancef, Lidocaine, and Tdap injections, had his wound sutured, and was discharged with instructions to follow up. (Id. at 29).

On October 25, 2019, Petitioner presented to Physicians Immediate Care ("PIC") with complaints of laceration of the left thumb. (Pet. Ex. 2 at 15). Petitioner was told to avoid strong gripping with his left hand, limit repetitive motion, was given new dressings, and had his thumb placed in a splint. (Id. at 17-18). Petitioner was told to return to the clinic on October 26, 2019 for a follow up. (Id.). In the interim, he was given a work restriction to avoid strong gripping with his left hand and to avoid repetitive motion. (Id. at 26). On October 26, 2019, Petitioner followed up with PIC. (Id. at 33). His work restrictions continued through November 3, 2019. (Id. at 34).

On November 10, 2019, Petitioner followed up with PIC. (Id. at 45). Petitioner stated that in the intervening period since his prior visit, he had travelled to Mexico to attend his father's funeral, and while there, a local doctor removed his sutures. (Trans. at 23-24). The PIC medical records reflect that he was informed by the doctor in Mexico to immediately stop wearing the splint. (Pet. Ex. 2 at 45). In Mexico, Petitioner also noticed increased swelling and numbness, which resulted in the doctor from Mexico administering a Clindamycin injection. (Id.) At the remainder of his November 10th follow-up, Petitioner presented with swelling, difficulty with range of motion and mild numbness. (Id.). Petitioner was administered a Ceftriaxone injection. (Id. at 47). Petitioner was advised to return to the clinic on November 14, 2019 for a recheck. (Id. at 48). Petitioner's work restrictions from October 25th were continued. (Id.). Petitioner was also instructed to continue wearing his thumb splint at all times. (Id.).

From November 14, 2019 through December 6, 2019, Petitioner presented to PIC for follow-up appointments. (Id. at 60-97). During that period, Petitioner continued taking Keflex, Bactrim and Tylenol for pain. (Id.). Petitioner described his severity as deteriorating – from mild to moderate during this period, with continued numbness, tingling, and swelling. (Id. at 72, 86, 90).

On December 6, 2019, Petitioner presented for a final follow-up at PIC. (Id. at 98). Petitioner continued to report 1/10 pain with continued swelling. (Id.). The reviewing physician continued Petitioner's restrictions but opined that the Petitioner was not complying with the care of his wound, which exacerbated his symptoms. (Id. at 100). It was also noted that Petitioner had not been wearing the splint to protect the fracture as instructed. (Id.). Although the wound was

healing, his range of motion was still affected, and therapy was recommended. (Id. at 101). Petitioner was instructed to stop wearing the splint. (Id.).

On December 11, 2019, Petitioner presented to Orthopedic and Rehabilitation Centers ("ORC") for treatment from Dr. Roberto Levi, M.D. ("Dr. Levi"). (Pet. Ex. 3 at 26). Petitioner gave a consistent account of his injury and complained of thumb pain and numbness on the medial side of the thumb and the tip of the thumb. (Id. at 27). Dr. Levi stated Petitioner's nail was half coming out and noted that Petitioner had a laceration of the medial digital nerve of the thumb which resulted in numbness in the finger. (Id.). Dr. Levi believed that Petitioner needed immediate surgical exploration and repair of the nerve and removal of the nail, however due to the one and a half months which had elapsed from the injury, any repair would be difficult. (Id.). Dr. Levi further noted Petitioner had his thumb immobilized for too long, which made it stiff. (Id.). Petitioner was diagnosed with an open fracture of the distal phalanx of the thumb, subungual hematoma, crush injury to the thumb and stiffness of the thumb secondary to immobilization. (Id.). Dr. Levi placed Petitioner off work as he was concerned that the wound could possibly become infected or contaminated with the grease utilized at his job. (Id. at 27, 29).

On January 7, 2020 Petitioner presented to ORC for physical therapy. (Pet. Ex. 3 at 60). It was noted that Petitioner had pain and difficulty moving his left thumb, had sensory deficits along the anterior and posterior aspects, and had difficulty making a fist. (Id. at 61). It was noted at Petitioner's January 9, 2020 physical therapy visit that Petitioner had good tolerance to initial treatment, but that there was limited motion, swelling, numbness, and hypersensitivity along the wound area. (Id. at 59). Future therapy would be directed to improve fine and gross motor skills, and improve grip strength and function while awaiting approval for hand surgery. (Id.).

On January 14, 2020 Petitioner followed up with Dr. Levi. (Pet. Ex 3 at 23-24). It was noted that the interphalangeal joint was very stiff. (Id. at 24). Dr. Levi maintained his recommendation that a surgical exploration of the wound was required with manipulation under anesthesia and possible repair of the medial digital nerve of the thumb. (Id.). Petitioner continued to be off work, as there was a continued concern that due to the lack of sensation, Petitioner could further injure his thumb. (Id.).

Petitioner continued attending physical therapy at ORC a total of ten (10) times from January 11, 2020 through February 6, 2020. (Id. at 38-57). At Petitioner's final physical therapy session on February 6th, it was noted that Petitioner continued to exhibit decreased range of motion due to decreased tissue and joint mobility – with limited function, sensory deficit and difficulty making a fist. (Id. at 39).

On February 5, 2020 Petitioner reported to Dr. Michael Vender ("Dr. Vender") for an independent medical examination ("IME") of his left thumb pursuant to Section 12 of the Act. (Resp. Ex. 1). Petitioner reported a consistent mechanism of injury relating to the October 24, 2019 accident, as well as reported the ongoing numbness and stiffness of the thumb. (Id.). Dr. Vender conducted a physical examination which noted a partial absence of the nail plate, a scar, swelling at the interphalangeal joint with tenderness, and tenderness of the thumb. (Id.). Dr. Vendor noted that there was no demonstration of symptom magnification, and also opined that Petitioner's current presentation was consistent with the residuals of the injury sustained – and not noncompliance with medical treatment. (Id. at 3). Lastly, Dr. Vender opined that that the injection of Clindamycin in Mexico could have been related to a possible infection, but that there were no records to conclusively determine this. (Id. at 4).

Dr. Vender reported that the Petitioner's treatment to date had been reasonable and necessary, and related to the work injury. (Id.). With regard to future care, Dr. Vender opined that

there was nothing to repair with regard to the nail plate and nail bed injury. (Id. at 4). Regarding the nerve injury, Dr. Vender indicated that there were no indications for exploration for possible nerve repair. (Id.). In his opinion, the degree of scarring and thickening in the injured area would prevent even the simplest nerve repair. (Id). Ultimately, it was Dr. Vendor's belief that a surgical procedure would not return any sensation to the injured area. (Id.). Based upon that conclusion, Dr. Vendor could not estimate when maximum medical improvement would be achieved. (Id. at 5).

Dr. Vendor asserted that Petitioner could perform work activities. (Id. at 4). Petitioner would have to be provided with a digit cap to protect the injured area, and that if difficulties arose while working on the set-up machine, they would have to be specifically addressed at that time. (Id.). Dr. Vendor also anticipated potential problems if Petitioner was required to perform significant forceful activities with his injured thumb on a repeated basis. (Id. at 4).

On February 12, 2020, Petitioner presented to Dr. Levi at ORC for a second follow-up. (Pet. Ex. 3 at 21-22). Dr. Levi noted persistent stiffness, numbness at the tip of the thumb and while there was no pain, the left thumb nail would eventually fall off. (Id. at 22). Dr. Levi asserted that Petitioner could return to work, albeit with minimal use of the left hand and not in the job that he had been performing previously. (Id.). At this time surgery had not been authorized. (Id. at 21-22).

Petitioner returned for a follow up appointment with Dr. Levy on April 20, 2020. (Id. at 18-20). Dr. Levi's records recorded that Petitioner was still having stiffness of the left thumb and some pain. (Id. at 19). Petitioner was released to full duty work status. (Id.). Petitioner returned to Dr. Levi for a final time on June 8, 2020. (Id. at 15-17). Dr. Levi noted that the thumb was incredibly stiff and repeated his conclusion that a nerve exploration and repairs should have been performed at the outset of the injury. (Id. at 15). Dr. Levi concluded that the injury would be chronic and permanent – with permanent stiffness and permanent lack of sensation. (Id. a 16). Dr. Levi asserted that the only possible treatment left at this time was an exploration and nerve graft, but that such a procedure would unlikely lead to long term restoration of sensation or mobility. (Id.). Although Petitioner had been released to full duty at the April 20th appointment, there was a off duty work form issued at the June 8, 2020 appointment. (Id. at 29).

Testimony of Jeffrey Kubas

Jeffrey Kubas ("Mr. Kubas") testified that he is currently the executive vice president of Vertex Resource Group which is a group of HR companies specializing in staffing, employee leasing, and recruiting. (Trans. at 41). As executive vice president, he is in charge of overseeing strategic operations of recruiters, finances, and sales for the Respondent. (Id. at 42). Recruiters would be in charge of taking in orders from clients, advertising, recruiting, placing, and communicating with the employees whether they were candidates looking for a job, or were currently working employees. (Id. at 43). Recruiters kept records of every phone call they make while trying to place employees, including interview setups, notes for personal interviews, submission to clients, any calls for time off work, disciplinary action, and missed days. (Id.) All of this information would be documented in an employee file. (Id. at 44).

Mr. Kubas testified that in the regular course of business, he regularly reviews job logs and job entries that are entered by the recruiters in their internal database system, Vertext. (Id. at 52, 55). Mr. Kubas testified to personally reviewing Petitioner's employment file as early as the day before trial and that he had personal knowledge of Petitioner's employment file and its contents

therein. (Id. at 52-54). Mr. Kubas testified Petitioner has been employed with Respondent since May 2019 and has an employment file with Respondent. (Id. 45). In Petitioner's employment file, Petitioner signed a Spanish-language document detailing Respondent's policies and procedures. (Id. at 45-46). Mr. Kubas testified that the policies and procedures state that employees are instructed to let the Respondent know when he or she would be missing or late for work and failure to do so can be grounds for termination or interpreted as job abandonment. (Id. at 47).

Mr. Kubas testified he was familiar with Petitioner's workers' compensation claim. (Id.). Mr. Kubas testified that Petitioner was taken off work by his doctor, but the note was later clarified stating Petitioner was able to return to work with some restrictions. (Id. at 48). Mr. Kubas testified that Respondent was able to accommodate Petitioner's one-handed work restrictions. (Id. at 49).

Mr. Kubas testified that Respondent first reached out to Petitioner in December 2019 with a job offer of one-handed work, and again on January 11, 12 and 13, 2020. (Id. at 51, 56). Mr. Kubas testified that to the best of his recollection, Petitioner accepted the job offer on January 13, 2020, but never reported to work on January 12, 13 or 14. (Id. at 56-57). Mr. Kubas testified that Respondent determined Petitioner abandoned his job as he turned down work accommodations by failing to appear for work. (Id. at 57-58).

On cross examination, Mr. Kubas testified that he could not remember the specific dates where Petitioner's status changed, and that Respondent did not contact the Petitioner's treating physician. (Id. at 63-64). Mr. Kubas also testified that the Respondent's internal tracking and employment systems did not contain any documentation detailing the job accommodations which were offered to Petitioner. (Id. at 67-68).

Petitioner testified that he had received a phone call from Respondent on December 17, 2019 regarding a one-handed job opportunity, but that he had turned it down due to his doctor's off-duty restrictions. (Id. at 30). Petitioner also testified that he received a one-handed job offer on or about January 11, 2020 but that he did not accept it on his doctor's orders because "it was full of oil". (Id. at 32). Petitioner could not remember receiving a call on January 12, 2020. (Id. at 32-33). Petitioner vaguely recalled receiving a call from Respondent on January 13, 2020 wherein he was offered a job on the third shift, which Petitioner could not accept. (Id. at 33). Petitioner testified that he made attempts to send in his doctor's notes to the Respondent, and then asked his brother to go to the Respondent in person to deliver said notes as a redundancy. (Id. at 33-34). Ultimately, Petitioner did not attend work at any point in January 2020. (Id. at 34). Petitioner recalled at some point he sought to return to work based upon Dr. Levi's eased restrictions in February 2020, but he was informed that he had been "fired". (Id. at 16, 19, 34-35).

Petitioner testified that he continues to suffer from throbbing pain in his thumb along with not being able to use his thumb. (Id. at 21). Petitioner testified his thumb has little strength. (Id.). Petitioner further testified that he takes medication for pain when needed, and that he wishes to undergo the surgery recommended by Dr. Levi. (Id. at 22). Petitioner testified that as of approximately July 2020, he was employed by a different employer. (Id. at 28).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact as applied by the Conclusions of Law which immediately follow:

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

The Arbitrator finds credible the testimony of both Dr. Levi and Dr. Vender who agree that the condition of Petitioner's left thumb is causally related to the undisputed injury which occured during his employment with Respondent. The Arbitrator also relies upon Petitioner's credible testimony relative to the specifics of his injury and its ongoing symptoms, which is consistently corroborated by all the medical records available in this case as well as Dr. Vender's IME report.

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 repeats the findings set forth in support of (F) as set forth fully herein.

As a preliminary matter, the Respondent agreed by stipulation to pay medical charges incurred prior to February 5, 2020. (Arb. Ex. 1). The Arbitrator finds that the treatment that Petitioner received from Orthopaedic and Rehabilitation Centers (Pet. Ex. 3) and Persistent RX (Pet. Ex. 4) constituted necessary medical care reasonably required to cure or relieve Petitioner of the effects of his work injury, and therefore said bills resulting from said treatment are the responsibility of the Respondent pursuant to Section 8(a) of the Act, as applied through the fee schedule or as otherwise negotiated.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator repeats the findings set forth in support of (F) and (J) as set forth fully herein.

The Arbitrator finds that Petitioner is entitled to prospective medical care. As of the date of hearing, Petitioner had undergone a course of physical therapy and exhausted all conservative efforts to alleviate his pain and numbness. The Arbitrator assigns great weight to the opinion of Dr. Levi indicating that Petitioner's condition will be chronic and permanent without the recommended nerve exploration and repair. (Id).

The Arbitrator acknowledges the conclusions of Dr. Vender insofar as it is his opinion that the nerve exploration and repair would unlikely yield any benefit for the Petitioner, however there is no evidence to indicate that such surgery would be detrimental to Petitioner. Given that the proposed surgery remains prescribed, and Petitioner has expressed his desire to undergo the surgery, the Arbitrator finds that Petitioner is entitled to undergo the surgical treatment prescribed.

L. What temporary benefits are in dispute? (TDD).

The Arbitrator repeats the findings set forth in support of (F), (J), and (K) as set forth fully herein.

The Arbitrator finds that Petitioner is entitled to TTD benefits from December 11, 2019 through April 20, 2020. Between the date of accident and December 11, 2019, Petitioner had continued working for Respondent until placed off duty by Dr. Levi due to concerns about Petitioner's exposed thumb possibly becoming infected or reinjured due to numbness. (Pet. Ex. 3 at 27, 29). Petitioner remained on off-work duty through February 12, 2020, at which time Dr. Levi released Petitioner to restricted work duty. (Id. at 21-22). This restricted work duty was not accommodated because Respondent considered Petitioner as having abandoned his job on January 15, 2020. (Trans. at 57-58). Petitioner was eventually released to full work duty by Dr. Levi on April 20, 2020. (Pet. Ex. 3 at 18-20). The Arbitrator finds Dr. Vender's conclusion that Petitioner could have returned to work to be less credible than Dr. Levi's opinion, notwithstanding the lack of any such offer for work made by Respondent to the Petitioner subsequent to the IME report.

Mr. Kubas testified that Petitioner had been offered work accommodations in line with his work restrictions in December 2019 and January 2020. (Trans. at 51, 56-58). However, these offered accommodations to return to work were not in line with Dr. Levi's restrictions – off-work duty. The Arbitrator finds credible Petitioner's testimony acknowledging that the work duty had been offered at those times, but that he did not accept it due to Dr. Levi's restrictions. (Id. at 32). Once Petitioner was issued work restrictions, Respondent had already considered him discharged and offered no evidence that they offered him restricted work duty in February 2020. Therefore, TTD benefits continued to accrue through the full release date of April 20, 2020, at which time the Petitioner's condition appears to have stabilized according to Dr. Levi.

Signed: _____ 3/4/2021
SIGNATURE OF ARBITRATOR DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC034354
Case Name	KINSEY, NIKITA v. STATE OF ILLINOIS - ILLINOIS YOUTH CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0128
Number of Pages of Decision	16
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Adam McCall

DATE FILED: 4/8/2022

/s/Maria Portela, Commissioner

Signature

22IWCC0128

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

NIKITA KINSEY,

Petitioner,

vs. NO: 17 WC 34354

STATE OF ILLINOIS –
IL YOUTH CENTER ST. CHARLES,

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, causation, temporary total disability, medical expenses and nature and extent, and being advised of the facts and law, affirms and adopts, with the following changes, the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Accident

Respondent argues that Petitioner did not sustain a work-related accident because the assault by her supervisor was personal to her. Although we agree with the Arbitrator's finding of accident, we expand upon the legal rationale by considering *City of Springfield v. IC*, in which the appellate court found:

> Rape, sexual assault, and battery are all physical bodily injury crimes in Illinois. See 720 ILCS 5/12-13, 12-3 (West 1992). For purposes of battery and aggravated sexual assault, bodily harm may be shown by either actual injury, such as bruises, or may be inferred by the trier of fact based upon common knowledge. *People v. Lopez*, 222 Ill. App. 3d 872, 879, 584 N.E.2d 462, 467, 165 Ill. Dec. 283 (1991). Therefore, we find that it was proper for the Commission to infer that a nonconsensual sexual assault was likely to involve

> physical trauma, and it was appropriate to characterize claimant's injury as a "physical-mental" trauma, as opposed to a "mental-mental" trauma.
> …
> Claimant's unrebutted testimony supports the Commission's conclusion that her supervisor committed repeated sexual assaults against her, and unrefuted medical evidence showed that, as a result, she suffered from post-traumatic stress disorder. It cannot be said, therefore, that the conclusion opposite that of the Commission's is clearly apparent from the record.
>
> **Finally, we note that it is well settled that a physical assault by a coworker can constitute an accidental injury under the Workers' Compensation Act** (820 ILCS 305/1 *et seq.* (West 1992)). *Meerbrey v. Marshall Field & Co.*, 139 Ill. 2d 455, 463, 151 Ill. Dec. 560, 564 N.E.2d 1222, 1226 (1990); *Collier v. Wagner Castings Co.*, 81 Ill. 2d 229, 238, 408 N.E.2d 198, 202, 41 Ill. Dec. 776 (1980).

City of Springfield v. IC, 291 Ill. App. 3d 734, 739-40, 685 N.E.2d 12, 15-16 (4th Dist. 1997) (Emphasis added).

Therefore, the Commission finds that the sexual assault by Petitioner's supervisor constitutes a physical-mental trauma and a compensable work-related accident that arose out of and in the course of her employment.

Nature and Extent

We agree with the Arbitrator's analysis of the first four permanency factors under §8.1b(b) of the Act. However, for factor (v), we replace the phrase "greater/lesser/no" with the word "greater."

We also believe the reference to Dr. Link's testimony that Petitioner was "not fully recovered" is inconsistent with the Arbitrator's finding that Petitioner had reached maximum medical improvement on June 22, 2018, based on Dr. Hartman's opinion. We therefore strike the sentence that indicates Petitioner had not fully recovered and specifically affirm that Dr. Hartman's opinion was the most persuasive in this case.

Other Corrections

In the last sentence of Section (F) on page nine, we replace the phrase "maximum medical improved" with "maximum medical improvement."

In the second paragraph on page three, we clarify that the Arbitrator's statement that Petitioner reported the incident to a "JJS" refers to a Juvenile Specialist whose name Petitioner could not recall. *T.14*.

On page three, in the fourth sentence of the third paragraph, we replace the phrase "her brother" with "a family member" to reflect Petitioner's testimony more accurately. *T.30-31*.

At the end of the second full paragraph on page seven, the Arbitrator wrote, "No evidence to directly contradict her testimony or to advance any ulterior motive for her complaint was offered." *Dec. 7*. We strike the phrase "or to advance any ulterior motive for her complaint" since it is inconsistent with the Arbitrator's discussion, a few paragraphs later, about the opinion of Dr. Hartman including that Petitioner "is deliberately feigning impairment for secondary gain and using the work event as the ostensible cause of her malingered claim." *Dec. 8*.

At the bottom of page seven, we strike the Arbitrator's citation to *Lopez v IWCC* because it was inappropriate to cite to an unpublished Rule 23 order that was issued prior to January 1, 2021.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2020, is hereby affirmed and adopted with the changes noted above.

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

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

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.

April 8, 2022

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

SE/
O: 2/15/22
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0128

KINSEY, NIKITA
Employee/Petitioner

Case# **17WC034354**

ST OF IL-ILLINOIS YOUTH CENTER ST CHARLES
Employer/Respondent

On 3/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

6368 ASSISTANT ATTORNEY GENERAL
NDUBUISI "VINCENT" OBAH
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

MAR 2 - 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nikita Kinsey
Employee/Petitioner

v.

State of Illinois-Illinois Youth Center St. Charles
Employer/Respondent

Case # **17** WC **34354**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **January 14, 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 _____

FINDINGS

On **October 22, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,296**; the average weekly wage was **$1,121.07**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$15,054.97** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$15,054.97**.

Respondent is entitled to a credit of **$739.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $747.38/week for 34 5/7 weeks, commencing October 23, 2017 through June 22, 2018, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $15,054.97 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,283.00 to Northwestern Medicine Kishwaukee Hospital, and $289.00 to Dr. Link, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $739.00 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 $672.64/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

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

Signature of Arbitrator

February 27, 2020
Date

ICArbDec p. 2

MAR 2 - 2020

Statement of Facts

Petitioner Nikita Kinsey testified that on October 22, 2017, she was a Juvenile Support Specialist for Respondent State of Illinois Youth Correctional Facility in St. Charles. She had been employed since 2015 or 2016. On that date, she testified that she was working in a cottage that was single staffed. She was in the cottage's office when her supervisor was performing his rounds and came into the office where Petitioner was working. He sat down next to her and started talking to her. He suddenly pulled up her shirt, started fondling her breasts, and began sucking on her nipple. Petitioner testified that she was in shock, became numb, nervous, quiet, and tried to figure out what to do. She attempted to pull down her shirt and get away, but he continued to forcefully pull up her shirt. Then he began to reach his hands into Petitioner's pants. She "bared down" and again told him to stop and told him that she was not comfortable. Petitioner's supervisor removed his hands, backed away, and carried on with his day. Petitioner testified that she did not have any kind of personal relationship with her supervisor nor were his actions permitted by her or consensual.

Petitioner tried to block the events out and continue working. She was embarrassed and wanted to avoid telling anyone about the sexual assault. The next day, she reported it to a JJS and the superintendent of the facility. A written statement was taken by her employer and Petitioner went to the hospital.

On October 23, 2017, Petitioner presented to Northwestern Medicine Kishwaukee Emergency Department (PX 3). Petitioner reported that a coworker sexually abused her. Petitioner reported she had been molested when she was younger (PX 3). Petitioner testified to being molested by her brother when she was 17. Petitioner testified she had no counseling or therapy following that incident. Petitioner complained of nightmares and feeling anxious. The St. Charles police were notified, and they inform the medical staff that this was jurisdiction of the Illinois State Police. The Illinois State Police were notified, and an officer was sent out. Petitioner did not have any physical injuries or any physical complaints. Petitioner reported alcohol use was two drinks or equivalent per week. Petitioner's psychiatric exam noted normal mood and affect. Petitioner was given Xanax so she could sleep for the night. She was instructed to follow-up with doctor if she is still feeling anxious. Petitioner requested three days off work and to be admitted. A Safe Passage counselor and the officer spoke with Petitioner. Petitioner was discharged.

On October 24, 2017, Petitioner submitted to the collection of evidence via a rape kit. Petitioner had a medical screen performed. A DNA swab was obtained from Petitioner's left nipple. The swab was labeled and sealed in front of Petitioner. Petitioner declined other portions of the kit at this time. Petitioner's bra was placed in bag and sealed. Petitioner reported she did not think she had bathed since the event (PX 1).

Petitioner began therapy with a counselor from Safe Passage on October 23, 2017. She reported a history of sexual assault by her supervisor consistent with the history contained in her medical records and testimony. Petitioner was provided with counseling, guidance, and protective services from the personnel at Safe Passage from October 23, 2017 through January 24, 2018. Their records note the description of the incident as well as the prior sexual molestation (PX 6). Their legal advocacy group also helped Petitioner obtain an order of protection against her supervisor (PX 6).

On October 26, 2017, Petitioner saw her primary care physician, Dr. Darryl Link. She reported a consistent history of the sexual assault by her supervisor. She reported that she was depressed by the event, was sleeping poorly, and anxious about return to work going forward. Dr. Link diagnosed Petitioner with acute anxiety as a reaction to sexual assault and reactive depression. Petitioner was prescribed Lexapro and Ativan.

Dr. Link stated he would arrange FMLA paperwork and return to work when she was emotionally recovered. He prepared disability paperwork (PX 4).

Petitioner began receiving treatment at Ben Gordon Center on November 6, 2017 upon the referral of Dr. Link. She described her current situation and reasons for seeking treatment as she was sexually assaulted by her supervisor at work. Petitioner felt confused, tired, sad, depressed, anxious, and experienced "overwhelming" worry. She noted many symptoms of the Depressive Cluster, all symptoms of the Anxious Cluster and most symptoms of the Trauma Cluster. Petitioner noted substance abuse issues. She reported her symptoms have been a problem for more than 2 years. She reported precipitating events including stress at work, health problems, an inability to cut down alcohol, recent/past trauma, re-occurrence of symptoms and being a victim of sexual violence. She noted prior psychiatric evaluation at 17 years old. She noted minimal prior substance abuse problems and moderate current problems. She reported alcohol use since age 16 of a couple of glasses daily (PX 5). She was diagnosed with acute stress disorder and moderate alcohol use disorder. She noted she had been called into work every day since the incident. She reported that Safe Passage did nothing for her. Her prognosis was fair. A psychiatric evaluation was recommended (PX 5).

Petitioner underwent therapy at Ben Gordon Center beginning November 13, 2017. Petitioner attended group and individual sessions. On November 27, 2017, she had a session with Dr. Qazi. She reported that she was having dreams about what happened at work and had been hypervigilant. She noted that investigation ongoing and stated that the supervisor has been fired. She reported that she was molested by a family member as a child and the recent sexual assault at work brought back memories. She reported that she started drinking to cope with her ongoing symptoms. She reported a new boyfriend of 2 months. She noted that she has not noticed much difference with the medications prescribed by Dr. Link. Dr. Qazi recommended continued psychoeducation (PX 5). On December 20, 2017, Petitioner advised that she is still drinking on the weekends and not taking her Lexapro. She asked for FMLA paperwork (PX 5).

Petitioner returned to Dr. Link on January 4, 2018 for a follow up. She continued to struggle with post-traumatic symptoms and had been working with a psychiatrist and counselors. Dr. Link notes it is online management rather than face-to-face. Petitioner did not notice any improvement. She stated she is unable to consider return to work to the workplace where the incident occurred. She notes a new sexual partner. She reports no physical disability. Dr. Link kept her off work and recommended continued psychiatric care and counseling and continued her prescription of Lexapro (PX 4). On February 8, 2018, Dr. Link noted that she was told that the perpetrator would be arrested but had not been at that point. She was only sleeping four to five hours a night due to anxiety. Dr. Link recommended Petitioner continue psychological and psychiatric treatment. He kept her off work. On March 9, 2018, Dr. Link noted that Petitioner was feeling more depressed and was not eating. She continued to have anxiety and depressive symptoms. She was not taking the prescribed Lexapro because she could not afford the costs. Dr. Link prescribed Petitioner Citalopram. (PX 4).

On March 5, 2018, Petitioner was seen at her residence by a counselor. She was in her pajamas. It was noted she was unable to focus and was struggling with managing her mental health symptoms. Petitioner was contacted by Ben Gordon Center on March 21, 2018. They advised she had not been seen since December 18, 2017 and had not spoken with them since March 1, 2018. On March 30, 2018, she was seen for alcohol use. She was set up for 60 days of case management, group and individual counseling (PX 5).

On March 27, 2018, Petitioner was evaluated by David Hartman, PhD, at the request of Respondent pursuant to Section 12. He issued his written report of the examination on June 22, 2018 (RX 3). Petitioner testified that

the appointment was approximately three hours long and consisted of answering questions for a half hour and sitting at a computer and answering questions for two to two and a half hours. While answering computer based questions, Petitioner became tired, exhausted, overwhelmed, and uncomfortable with the questions. She asked whether she could stop but was pressed to continue.

Petitioner reported that she was depressed and had nightmares about going to work and seeing the man who assaulted her. Petitioner stated that she "drinks a lot to get drunk." Petitioner stated that she has been going to counseling sessions at the Ben Gordon Center, but she was "so depressed" that she "forgets" her appointments. Dr. Hartman noted Petitioner's general demeanor was sullen, reticent, and angry. Petitioner was passive aggressive and failed to cooperate with repeatedly presented instructions by Dr. Hartman. Dr. Hartman administered numerous psychological tests to the Petitioner. Dr. Hartman concluded that Petitioner's test patterns were "extreme, implausible, and, in one case, faked with deliberation." He concluded that the Petitioner's extreme and feigned test patterns indicated that her claimed state of disability is implausible (PX 3).

Dr. Hartman believed that there were no objective tests of psychological dysfunction and believed that the objective findings of his computer based tests were positive for deliberately malingered impairment and passive aggressive failure to cooperate with repeated instructions. He believed there was no indication of anxiety or depression. He diagnosed her with alcohol addiction. He opined the only connection between the event in question and the current symptoms is opportunistic. Petitioner is deliberately feigning impairment for secondary gain and using the work event as the ostensible cause of her malingered claim. Malingering is not a form of psychopathology or trauma, but a deliberate choice to feign or simulate symptoms to obtain a rewarding outcome. He did not believe that she required any treatment for the sexual assault at work and that her alcohol dependency was not related to the work event. He believed that she did not require work restrictions because her symptoms and fears of returning to work and facing her assailant were fabricated for the purposes of monetary gain. Dr. Hartman concluded the Petitioner was not in need of treatment and was at MMI (RX 3).

On April 23, 2018, Petitioner was seen by Linda Myers at Ben Gordon Center. The records note she endorsed every symptom of the PHQ-9 and GAD-7. She reported drinking one glass of tequila or wine per week to ease her anxiety. She reported she has not returned to work. She is frustrated with the ongoing investigation. She is looking of jobs in Arizona and plans to move there ASAP (PX 5).

On May 25, 2018, Petitioner saw Dr. Link. She noted the delay in the investigation. She reported she was unable to return to work due to the presence of the alleged perpetrator of the assault. Dr. Link prepared additional off work paperwork. He increased her dose of Zoloft to 50 mg (PX 4). On June 4, 2018 at the Ben Gordon Center, Petitioner noted more symptoms since testifying at the hearing where her attacker was present. She notes that she and her boyfriend are trying to start a family. She reports that she drank once since starting her medication. On June 18, 2018., Petitioner advised she was had passed the written test for CPD and was preparing for the physical test. The counselor noted no progress due to minimal engagement in therapeutic process. Petitioner was discharged July 16, 2018 (PX 5).

On July 24, 2018, Petitioner saw Dr. Link with her boyfriend. She continues to struggle with anxiety and mood symptoms. She reported her providers at Ben Gordon Center are leaving. Dr. Link notes she is unable to return to work because the alleged perpetrator of her sexual assault is still at the work site. She did not complete the running test for the CPD. She appeared well, in no real distress. She does display some

animation with smiling and responsiveness. Dr. Link increased her medication dose and continued her off work until October (PX 4). On October 9, 2018, Petitioner advised Dr. Link she is ready to return to work. She is 15 weeks pregnant and under restrictions from her OB due to the pregnancy. She continues to try and find a psychiatrist. She is off her medication. Petitioner was released to return to work (PX 4).

Dr. Link testified by evidence deposition taken September 30, 2019 (PX 7). He testified that he was board certified in internal medicine and general pediatrics. About 60% of his practice is pediatrics. He is not certified in psychology, neurology, or forensic neuropsychology. He was Petitioner's primary care physician. He had been in primary care since 1991. Dr. Link did not have any recollection of treating Petitioner for anxiety, depression, panic attacks, fearfulness, or post-traumatic stress disorder prior to October 22, 2017. He saw Petitioner October 26, 2017, after she was sexually assaulted at work. She had no physical issues. His feeling was she was suffering from acute anxiety and mood reaction from the occurrence. He did not perform any psychological exams. He reached his diagnosis from the historical information and symptoms and reaction. He did not perform any symptom validity, cognitive, word memory, structured inventory or personality assessment testing. He did not review any learned treatises or consult with any psychologist or psychiatrist in making his diagnosis (PX 7).

He testified that he referred Petitioner to psychological and psychiatric care. He started her on prescriptions for anti-anxiety and anti-depressant medication. He oversaw Petitioner's treatment and prescribed medications at the outset, but then relied on the psychiatrist's care to provide ongoing medication recommendations and any other appropriate treatment. He testified it was his understanding that Petitioner obtained behavioral health, cognitive therapy, and psychiatric care. He opined that Petitioner did not have an issue with the correctional system. Her problem was related to having to go back to employment with the individual that started this issue still employed in that system. He opined that her anxiety disorder was causally connected to the incident she suffered at work. Dr. Link further testified that Petitioner improved during the course of her treatment, got better and ultimately returned to work, but he did not believe that she fully recovered from her disorder (PX 7).

Superintendent John Albright testified at trial. He testified that he began working as the superintendent at St. Charles Illinois Youth Center in March of 2018. Prior to that, he worked as the assistant superintendent beginning in September of 2017. He was aware of Petitioner's alleged sexual assault. Mr. Albright stated that the Illinois State Police conducted an investigation and turned the findings to the State's Attorney. He was informed on January 20, 2019 that the State's Attorney would not file charges. After receiving this information, the Department of Corrections conducted an investigation. That investigation came back unfounded in September 2019. The supervisor alleged was not allowed on the premises during the investigations. After that, the supervisor was returned to work. He is currently employed at IYC in the same capacity. Mr. Albright was present during Petitioner's testimony. He testified that Petitioner's testimony was what she understood her belief to be. He has no information to suggest Petitioner is lying.

Petitioner testified that she struggles with symptoms of anxiety, depression, worthlessness, exhaustion, irregular sleeping patterns, and paranoia. Her relationships with other people have been affected as she had a short temper and pulled away from others. Petitioner testified she was drinking three to four days a week. She would drink half a bottle of tequila a week. She abstained from drinking and had not had a drink since she was transferred to another facility.

Petitioner testified that she feared returning to work while her supervisor was still employed by Respondent. She was afraid that he would be at work and she had dreams about him approaching her and working near

her. Petitioner did not feel safe around the juvenile inmates, some of whom were sexually violent, and did not feel any safer around her coworkers. She stated that she did not believe that she could protect herself if required to do so at work. Before transferring to a different facility, she would still encounter her supervisor at work and felt unsafe until she found another job. Petitioner is currently working for IYC Chicago. She transferred there in April 2019. Since returning to work she is doing better. She is not drinking. She has improved due to the different location.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. 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 to a physical assault while at Respondent's facility resulting in her psychological injury. The incident as described occurred during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties and originated from a risk incidental to her employment, namely interaction with her supervisor. If Petitioner is believed, the incident described is an accident arising out of and in the course of her employment.

The Arbitrator does not find the fact that the investigations performed did not result in either the criminal charging or discharge of the supervisor from employment sufficient to overcome Petitioner's direct testimony concerning the incident. The Arbitrator notes that Petitioner reported the incident the next morning and has provided a consistent history of the events to the police, employer and medical providers. She participated in testifying at the investigation. No evidence to directly contradict her testimony or to advance any ulterior motive for her complaint was offered.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that she sustained accidental injuries arising out and in the course of her employment with Respondent on October 22, 2017.

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 Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. *Lopez v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130355WC-U, P25 (Ill. App. Ct. 3d Dist. 2014).

Petitioner was diagnosed with acute anxiety as a reaction to sexual assault and reactive depression by Dr. Link her primary care physician. He confirmed that there was no physical injury. He took her off work and referred her for psychological counseling. She was seen at Ben Gordon Center with an initial diagnosis of acute stress disorder and moderate alcohol use disorder. She underwent counseling sessions thereafter.

Petitioner was seen by Dr. Hartman who administered a battery of computer tests and opined that that there were no objective tests of psychological dysfunction and believed that the objective findings of his computer based tests were positive for deliberately malingered impairment and passive aggressive failure to cooperate with repeated instructions. He opined the only connection between the event in question and the current symptoms is opportunistic. Petitioner is deliberately feigning impairment for secondary gain and using the work event as the ostensible cause of her malingered claim. Malingering is not a form of psychopathology or trauma, but a deliberate choice to feign or simulate symptoms to obtain a rewarding outcome. He did not believe that she required any treatment for the sexual assault at work and that her alcohol dependency was not related to the work event. He believed that she did not require work restrictions because her symptoms and fears of returning to work and facing her assailant were fabricated for the purposes of monetary gain. Dr. Hartman concluded the Petitioner was not in need of treatment and was at MMI.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. 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).

Having heard the testimony and reviewed the evidence, the Arbitrator finds that Dr. Link's initial diagnosis is in accordance with the presentation following the incident described. Given Petitioner's prior history, the acute reaction to the episode is consistent with her behavior in reporting the incident, having the follow up rape kit at the hospital, and pursuing the order of protection against the supervisor. The referral counseling at Ben Gordon Center, who concurred in the diagnosis of acute anxiety was also appropriate and causally connected.

The Arbitrator notes that the continued treatment was based exclusively on Petitioner's reporting of symptoms and complaints. There was no testing of any kind performed to verify them by the treating providers. Petitioner received minimal care at Ben Gordon Center. Their records note her lack of

involvement or participation. Dr. Link is a pediatrician with no psychological expertise. He noted he did not provide treatment but deferred to the psychological care. Given that the sole basis for the ongoing diagnosis, care and disability assessments was Petitioner's subjective presentation, the Arbitrator notes multiple inconsistencies in her actions. Petitioner testified she had no treatment after her prior sexual assault at age 17, but the records report that she had a psychological evaluation at that time. Petitioner states that she is not eating, but gained weight. Petitioner reported alcohol abuse, but the initial Ben Gordon Center records noted the condition had been ongoing for 2 years. Her initial hospital visit listed her alcohol consumption as the same as she reported thereafter, 2 large glasses per week. Petitioner reports no social involvement, yet she reports finding a new boyfriend, decides to start a family and, in fact, becomes pregnant in July 2018. She advances lack of motivation, but repeatedly describes her plans for new employment, moving to Arizona, or pursuing employment at CPD during which she passed the written examinations. The Arbitrator also notes Dr. Link's decision making is often based upon Petitioner's requests including continuing her off work and releasing her to return in October despite no change at all in the findings, diagnosis or circumstances of her employment.

The Arbitrator infers she had dissatisfaction with Respondent rather that a true ongoing disabling condition. The Arbitrator notes that the claim that she was afraid of confronting the alleged assailant is belied by the fact that he was suspended for the entire period through January 2019. In light of these facts, the Arbitrator finds that Dr. Hartman's opinion that, at the time of his examination, Petitioner was exaggerating her condition of ill-being consistent with the evidence. Dr. Hartman could not eliminate that there was a true underlying condition initially, but based upon his greater credentials, his objective testing performed, and the lack of any significant objective basis for an ongoing diagnosis, his opinion that as of the date he issued his report Petitioner had no disabling condition and was at maximum medical improvement is persuasive.

Based upon the record as a whole and the Arbitrator's finding with respect to Accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that, as a result of the accident on October 22, 2017, she suffered acute anxiety as a reaction to sexual assault and reactive depression causally connected to the accident. The causally related condition of ill-being reached maximum medical improved as of June 22, 2018, the date Dr. Hartman issued his report.

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 findings with respect to Accident and Causal Connection, reasonable and necessary medical care for Petitioner's acute anxiety as a reaction to sexual assault and reactive depression through the date of maximum medical improvement would be causally connected. Petitioner admitted PX 1 noting unpaid bills to Northwestern Medicine Kishwaukee Hospital ($3,022.00) and Dr. Link ($1,187.04). Respondent admitted RX 1 showing payments made.

The Arbitrator finds the bill of Northwestern Medicine Kishwaukee Hospital is for reasonable, necessary and causally related treatment. The billing reflects a group insurance payment by Blue/Cross Blue Shield of

$739.00 for which Respondent is entitled to credit under Section 8(j). Dr. Link's bill includes visits from October 26, 2017 through October 9, 2018. Based upon the Arbitrator's finding with respect to Causal Connection the office visits through May 25, 2018 would be reasonable, necessary and causally related. The bill submitted and the payment log agree that the outstanding charges for this period would be $132.00 for October 26, 2017 and $157.00 for May 25, 2018.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,283.00 to Northwestern Medicine Kishwaukee Hospital, and $289.00 to Dr. Link, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $739.00 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To be entitled to TTD benefits a claimant must prove not only that he did not work but that he was unable to work. *Freeman United Coal Min. Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 175, 741 N.E.2d 1144, 1148 (2000).

Petitioner began missing work the day after the October 22, 2017 incident. She went to the emergency department. She was referred to her primary care physician, who disabled her as of the date of the incident. Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner reached maximum medical improvement as of the date of the issuing of Dr. Hartman's report on June 22, 2018.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that she is entitled to temporary total disability benefits of 34 5/7 weeks, commencing October 23, 2017 through June 22, 2018, as provided in Section 8(b) of the Act. Pursuant to the stipulation of the parties and RX 1, Respondent shall be given a credit of $15,054.97 for temporary total disability benefits that have been paid.

In support of the Arbitrator's decision with respect to (L) Nature & Extent, the Arbitrator finds as follows:

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

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 Juvenile Justice Specialist at the time of the accident and that she is able to return to work in his prior capacity at a different facility as a result of said injury. The Arbitrator notes that Petitioner's extended off work was due to fear of having to work with her alleged assailant. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 31 years old at the time of the accident. She will be expected to remain in the workforce for an extended period of time. Because of the nature of this claim. The length of her work life does not necessarily correspond to the likelihood of reinjury. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner is working at a different facility. No evidence of earning loss was offered. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner was initially diagnosed with acute anxiety as a reaction to sexual assault and reactive depression causally connected to the accident. She received counseling for these conditions and alcohol abuse. Dr. Link released her to return to work without restrictions He stated Petitioner was better but not fully recovered. Because of these facts, the Arbitrator therefore gives greater/lesser/no weight to this factor.

In assessing disability in this matter, the Arbitrator finds the Commission decision in *Ramona Stampley v. Car-Lene Research*, 02 IIC 1003, 01 WC 7701, instructive.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of person as a whole pursuant to §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC007563
Case Name	MOULESONG, MICHAEL v. OSWEGO FIRE PROTECTION DISTRICT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0129
Number of Pages of Decision	20
Decision Issued By	Maria Portela, Commissioner, Kathryn Doerries, Commissioner

Petitioner Attorney	Nancy Shepard
Respondent Attorney	Patrick Jesse

DATE FILED: 4/11/2022

/s/Maria Portela, Commissioner

Signature

DISSENT

/s/Kathryn Doerries, Commissioner

Signature

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

Michael Moulesong,

Petitioner,

vs. NO: 18WC 007563

Oswego Fire Protection District,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2020 is hereby affirmed and adopted.

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

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

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 11, 2022

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

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DISSENT

I respectfully dissent from the majority. I would find that Petitioner has failed to sustain his burden of proving that his condition of ill-being in his right knee is causally related to the incident that occurred at work on February 21, 2018, irrespective of the issue of accident. I would reverse the award of temporary total disability and medical benefits and permanent partial disability for the following reasons:

Background

There is no question that Petitioner had a pre-existing condition in his right knee prior to the incident on February 21, 2018. In fact, Petitioner first saw his treating surgeon Dr. Burt, three months prior to the subject incident, on November 9, 2017, complaining of intermittent pain for five weeks that was worsening in his right knee, that he described as aching and sharp. The pain was reported to be aggravated by climbing stairs, movement, walking and standing. The associated symptoms Petitioner reported included decreased mobility, joint tenderness, popping and swelling. Dr. Burt noted joint instability. (PX3, RX3) Petitioner underwent a right knee MRI on November 13, 2017, which, according to the radiologist's impression, confirmed: 1) shallow partial thickness cartilage loss at the lateral and patellofemoral compartments; 2) fraying of the posterior root of the medial meniscus; and 3) small joint effusion and fraying at the free edge of the medial meniscus body. (PX3, RX4)

Dr. Burt thereafter documented that Petitioner's November 13, 2017, MRI showed "moderate CM patella" and administered a lidocaine injection in Petitioner's right knee on November 16, 2017, to calm his pain down, indicated and noted under his Assessment for "chondromalacia patellae, right knee." Dr. Burt recommended a few weeks of physical

therapy for the pain, however, returned Petitioner to work full-duty. Petitioner was to follow-up in one month.

Petitioner returned to Dr. Burt on December 15, 2017, reporting that he felt much better with the injection and physical therapy. He reported that he still had some soreness after workouts but he was doing fine at work and with daily life. On examination, there was still mild patellofemoral crepitus. Dr. Burt's Assessment listed "Chondromalacia patellae, right knee" and the Plan Comments stated: "If pain returns I would recommend arthroscopy/chondroplasty. "For now maintain HEP and follow-up prn."

Petitioner's Testimony

Petitioner testified that on the date of incident that as he was walking from inside of the station onto the bay floor to get on the engine to leave the building, that, "[a]s I was coming off, I twisted my knee…" (T, 10) Petitioner's attorney asked him to reiterate as follows:

Q. I think you mentioned this. But did your knee twist as you stepped?
A. I believe so, yes. (T. 11)

Petitioner then testified that he has arthritis in the right knee. (T, 11) Also, that when the injury occurred the pain was way more intense than his prior knee issues. He stated: "I wasn't currently having knee issue (sic) at the time." Then his attorney questioned him further and the exchange revealed the following:

Q. I think you just stated this. But before the injury occurred were you having any symptoms in your right knee?
A. No. (T. 11)

Petitioner then testified he had cortisone shots the year prior, that he did not remember when in that year, "[m]aybe 6, 7 months or so before the incident." (T, 12)

The history of present illness obtained from Petitioner in the medical records of Rush Copley Medical Center on the date in question, February 21, 2018, states as follows: "45-year-old male here with complaint of right knee pain after stepping down an 8 inch step. He reports on weight acceptance he felt the pain with a pop in his posterior knee. Reports that he can walk but with pain. Denies falling. Denies significant swelling." (PX2)

However, Petitioner reported to Dr. Burt two days later that after stepping, he had immediate sharp pain and "he fell down." (PX3 2/23/18 p. 8) Those two reports are inconsistent. Further, in addition to the fact that Petitioner's most reliable, initial history note states specifically that he denied falling, Lt. Roscoe, who witnessed the Petitioner's step, testified that Petitioner did not fall or trip. (T. 38) This is a critical factor because Dr. Burt provided a causal connection opinion, however, clearly the basis of his opinion is flawed. Further, neither of those initial medical histories mention twisting of any kind, yet Petitioner testified twice that he twisted his knee.

Testifying that he twisted his knee, which was not supported in the any medical history, and then choosing to embellish the length of time between the cortisone shot and the incident at bar, testifying it was "maybe six or seven months," instead of the barely three months' time that passed, speaks volumes. Petitioner also testified that he and his fellow firefighters were preparing to leave the station in order to go to training at another station followed by a grocery run. (Tr. 14) Lt. Rosco, however, testified that they were not on the way to training. (T. 41) In my opinion, cumulatively, these mistruths are enough to taint Petitioner's credibility. Further, Petitioner testified that prior to the incident he was not having any knee issues at the time and he wasn't having any symptoms in his right knee. This does not comport with Dr. Burt's office note on December 15, 2017, when he reported he was much better with the injection, but still had soreness after workouts. Further, upon examination he had crepitus.

Causal Connection Opinions

Dr. Karlsson's opinion, given to a reasonable degree of medical and surgical certainty, states:

> The final diagnoses is medial and patellofemoral arthritis and partial-thickness tearing of the media1 meniscus. I do not believe any of these diagnoses are causally related to work activities or the described activities on February 21, 2018. It should be noted that there was no distinct injury or trauma to the knee, but he describes stepping down a six to eight inch step. There is no description in any of the medical records of a pivoting injury, twisting injury or fall. The findings at the time of surgery are degenerative in nature with degenerative fraying of the meniscus, without a full-thickness tear and degenerative changes in the patellofemoral joint and medial joint line without loose bodies. There was no traumatic loose body or loss of cartilage on a traumatic basis, but it was described as moderate to severe grade 3 chondromalacia of the patella and grade 3 chondromalacia of the medial femoral condyle. These are degenerative in nature, and it should be noted that his complaints before injection are similar to his complaints at the time of presentation with difficulty with stairs, pain with motion, and noted to have decreased strength both from his preinjury and postinjury exams with Dr. Bert." (sic) (RX5)

Petitioner's attorney wrote Dr. Burt thereafter, enclosing Dr. Karlsson's report. His cover letter to Dr. Burt posed the questions (quoted below) and Dr. Burt provided three, one-word answers, which was then submitted into evidence as Dr. Burt's causation opinion. The letter was written and answered as follows:

> Mr. Moulesong alleges an injury to his right knee is a result of going down a single step in the firehouse. He advises that he felt his knee pop while descending the step on February 21, 2018.
>
> Dr. Troy Karlsson evaluated Mr. Moulesong's treating records without conducting an examination and authored an opinion regarding Mr. Moulesong's left knee condition. I am enclosing his report for your consideration. I am hopeful you will answer a few questions for me regarding Dr. Karlsson's opinion.

> Firstly, do you agree or disagree with his opinion that the injury as described by Mr. Moulesong did not contribute to his left knee condition? "Disagree"
>
> If you do disagree with Dr. Karlsson do you believe that the injury sustained on February 21, 2018 aggravated, accelerated or exacerbated his pre-existing left knee condition? "Yes" Do you believe it accelerated his need for the surgery that you performed? "Yes" (PX5) (emphasis added)

Dr. Karlsson's causal connection opinion is not only more persuasive than Dr. Burt's opinion but inherently more reliable for several reasons. First, as referenced, Dr. Burt's opinion was based on a false history of Petitioner falling as evidenced in his February 21, 2018, initial history, something Petitioner explicitly denied at Rush Copley and Lt. Roscoe, the eyewitness, confirmed did not happen. Further, Dr. Burt never testified or clarified in any way absent that history the reasons he agreed or disagreed with Dr. Karlsson's causal opinion.

In fact, the post-surgical initial evaluation physical therapy note after surgery documents that there were previously six sessions Petitioner attended. (PX4) Those notes are conspicuously absent from the record yet infer that when Dr. Burt referred the Petitioner back to therapy, it was treated as a continuation of the previous sessions with a new evaluation after surgery.

Dr. Karlsson provides some insight into those records, noting that on November 21, 2017, Petitioner reported knee pain for about one month limiting his ability to kneel, negotiate stairs, and bend his knee and that Petitioner had been given the injection on November 16, 2017. His current pain reading was rated as "3" and worst was reported as "6" following the injection. On exam, he had a mild degree of joint swelling, and he had moderately restricted medial patellar mobility. He had a mild Baker's cyst. Regarding function, he had difficulty with stairs, walking community distances, and standing for longer than twenty minutes. Dr. Karlsson noted that as late as December 7, 2017, therapy notes document that Petitioner had attended five appointments with improvement in kneeling tolerance but higher step-ups continued to be painful. (RX5)

Next, it is unrebutted that Petitioner's right knee condition is an inherently degenerative condition. (Rx5) The intake functional status summary of the Athletico therapy records on March 20, 2018, confirm that Petitioner had other health problems noted as arthritis and a BMI over 30 and further noted Petitioner was 67 inches, his weight was 250 pounds and his BMI was 39.2. (PX4) Petitioner testified that he experienced symptoms in his right knee before February 21, 2018, due to arthritis. (T. 22)

Likewise, there is no dispute that Petitioner's right knee condition that began approximately October 2017 and for which he sought treatment with Dr. Burt in November and December 2017, was unrelated to Petitioner's work for Respondent. Petitioner therefore bears the burden of proving a material change in his preexisting right knee condition caused by the February 21, 2018, incident such that either Petitioner's preexisting right knee condition was permanently aggravated or accelerated or that new injuries were sustained. Petitioner failed to prove either.

The majority finds that Petitioner sustained new and distinct injuries as a result of the February 21, 2018, incident. In support, the majority relies upon Petitioner's testimony that he

had an increase in symptoms following the accident and changes between the pre and post-accident right knee MRIs. I disagree with both. At trial, Petitioner testified that he was asymptomatic in his right knee immediately before the February 21, 2018, accident with extreme pain and symptomology afterwards.

However, the objective medical evidence shows that Petitioner's physical exam findings and complaints prior to the November 16, 2017, injection were similar in nature to those following the February 21, 2018, incident. (Rx5) While Petitioner did report his right knee symptoms had improved on December 15, 2017, two months before his alleged accident, that same treatment note shows that his symptoms had not fully resolved. Rather, after Petitioner first became symptomatic in October of 2017, as reported to Dr. Burt in the first office visit on November 9, 2017, none of his medical records document him returning to asymptomatic status. Further, the majority opinion notes that Dr. Burt had not mentioned surgery following the November 2017, MRI. This is patently untrue. Dr. Burt first tried a cortisone injection, and physical therapy, two methods of conservative management. Dr. Burt then specifically noted in December, 2017 that if the pain returned that he recommended an arthroscopy/chondroplasty surgery.

Conversely, as Dr. Karlsson explained, Petitioner's December 15, 2017, report of improvement in his symptoms with a return of the symptoms two months later in February 2018 followed the expected results of the lidocaine injection performed on November 16, 2017. It is unrebutted that the lidocaine injection is expected to provide relief that lasts anywhere from several weeks to several months. This timing is consistent with Petitioner's return of symptoms on February 21, 2018, following the activity of taking a single step as it was three months after Petitioner received the injection and only 8 weeks after his last visit to Dr. Burt where surgery was anticipated if the pain returned after the injection.

The majority, by adopting the Arbitrator's award, found 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 in certain circumstances. International Harvester v. The Industrial Commission, 93 Ill. 2d 59, 442 N.E.2d 908 (1982). I find that those circumstances are not present in this case as "[c]ases involving aggravation of a preexisting condition concern primarily medical questions and not legal ones." Long v. The Industrial Commission, 76 Ill. 2d 561, 565, 394 N.E.2d 1192 (1979).

The majority further found that this change in symptoms is therefore evidence, via a chain of events analysis, that he sustained separate and distinct injuries as a result of taking a step on February 21, 2018, specifically an ACL sprain. The operative report, however, confirms an intact ACL. The majority relies on a chain of events analysis, however, because Dr. Burt's opinion is inherently unreliable.

When Petitioner saw Dr. Burt on February 23, 2018, he reported there is no injury. All of his complaints were the same as when he first saw Dr. Burt on November 9, 2017. An "Additional information" notation states that he was walking to the truck bay at the fire station and stepped down the 6" step and felt a pop in his posterior and lateral knee and he had immediate sharp pain. Previously, at his very first visit to Dr. Burt on November 9, 2017, Petitioner reported his right knee was popping, thus his condition had not changed.

The Arbitrator and the majority next contend that there are differences between the November 2017 and March 2018 right knee MRIs. Dr. Karlsson rebuts that argument.

Dr. Karlsson opined that he did not see any significant difference between the two MRI studies with the exception of very minimal increase in the scant effusion. Dr. Karlsson opined that no large effusion is noted, there were no acute changes, and no fractures, dislocations, loose bodies or full-thickness meniscal tears noted. Both studies show degenerative changes in the posterior horn of the medial meniscus. (RX5)

There is no testimony or opinion from Dr. Burt confirming any inconsistency between the two MRIs or that the MRIs could have any bearing on the issue of whether or not Petitioner sustained a new injury. It would appear that both MRIs showed the same tear confirmed by the operative report and that therefore the tear was preexisting as confirmed by the November 16, 2017, MRI for which Dr. Burt recommended surgery in December just weeks before the incident at bar.

Based upon the similarities between the pre-accident MRI and the operative findings, it is clear that Petitioner's right knee condition was preexisting. This is supported by the opinion of Dr. Karlsson and Petitioner did not submit any medical opinion to the contrary.

The fact that a condition is preexisting is not an absolute bar to compensability. However, the Petitioner bears the burden of proving that a preexisting condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. Nunn v. Industrial Commission, 157 Ill. App. 3d 470,476 (4th Dist. 1987). Although medical testimony as to the causation is not necessarily required, when the question is one specifically within the purview of experts, expert medical testimony is mandatory to demonstrate the condition of ill-being and that the claimant's work activities caused such condition. Nunn v. Industrial Commission, 157 Ill.App.3d at 478.

The majority relies on Dr. Burt's one page and one word reply to questions posed by Petitioner's attorney to establish causation of Petitioner's condition. However, due to the nature of the report, the only conclusions that can be drawn from it are necessarily founded upon speculation and conjecture. (PX5) Dr. Burt did not elaborate on what portion of Dr. Karlsson's opinion he disagreed with. It is unclear whether he disagreed with the conclusions or rationale or whether he disagreed in part or in whole.

Dr. Burt does not explain whether he believed the accident caused an aggravation, an acceleration, or an exacerbation of Petitioner's condition. He similarly did not explain whether he believed the same was permanent or temporary and he never testified. We know the ACL was intact so even if, arguendo, the Petitioner sustained a sprain to the ACL, that is not the reason he had surgery.

Finally, in response to Petitioner's attorney's question of whether or not Dr. Burt believed the accident accelerated Petitioner's need for the surgery performed, Dr. Burt simply wrote "yes." (Id.) He again did not explain the basis for his opinion, whether or not the accident

necessitated the need for the surgery or whether or not Petitioner would have required the surgery regardless of whether or not the accident occurred. This lack of clarity is especially troublesome as Dr. Burt had recommended surgical intervention if pain returned just two months before the alleged accident occurred.

The opinions of Dr. Burt were flawed as they fail to explain his opinion on important distinctions between aggravation and exacerbation and temporary versus permanent. In relying upon the one word answers of Dr. Burt, the majority speculates as to Dr. Burt's opinions on important and dispositive issues. The opinions of Dr. Karlsson are better explained and better supported by the medical evidence. Dr. Karlsson was given the opportunity to review all of Petitioner's medical records, review the results of every physical examination performed, review every history Petitioner provided to his health care providers, and review the films of Petitioner's pre and post-accident MRIs. After studying all of Petitioner's medical records, Dr. Karlsson concluded that Petitioner had medial and patellofemoral arthritis and partial thickness tearing of the medial meniscus in his right knee.

Dr. Karlsson opined that the diagnoses was not related to the alleged work accident. He explained that the operative and MRI findings were all degenerative in nature and predated the accident as seen by the November 2017 MRI. Further, Dr. Karlsson opined that the incident on February 21, 2018, did not permanently aggravate or accelerate Petitioner's condition as Petitioner had similar complaints before and after the incident, including difficulty with stairs and pain with motion. Finally, Dr. Karlsson explained that stepping down a six to eight-inch step could not cause a distinct injury or trauma to the knee with no description in the medical records of any pivoting, twisting, or fall.

I find Dr. Burt's "opinion," or more aptly, his words of agreement and disagreement without explanation, not credible and entitled to little weight. See, e.g., Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n, 2014 IL App (3d) 130028WC, 14 N.E.3d 16, 383 Ill. Dec. 184 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

There is no evidence in the record of whether or not Dr. Burt referred back to his office notes when he answered the questions posed by Petitioner's counsel. If he did, he saw that on March 23, 2018, Petitioner reported that he fell. The notes from Rush Copley on the subject date in question very clearly state that Petitioner denied falling and this was confirmed by Lt. Roscoe. In addition, three questions posed to Dr. Burt refer to Petitioner's left knee. There is nothing in the record that corrects those references, questions and answers pertinent to Petitioner's left, not his subject right knee. Even if we presumed, arguendo, that those are typographical errors, Dr. Burt wrote nothing to clarify or correct the wrong body part. Coupled with his one word answers, this failing infers that Dr. Burt answered the questions carelessly, and further renders his opinion as unreliable.

Dr. Karlsson believed that the symptoms Petitioner experienced after the February 21, 2018, accident were from the pre-existing degenerative changes in the right knee, rather than any type of new injury or condition. Dr. Karlsson ultimately concluded that Petitioner's pre-accident symptoms had returned with normal activity of daily living after the cortisone steroid injection had worn off. His opinions on causation are supported by the objective medical evidence. I would

rely upon the clear and supported opinions of Dr. Karlsson regarding causation rather than the unexplained opinions of Dr. Burt.

Therefore, I dissent from the majority opinion and would reverse the Arbitrator's decision awarding temporary total disability and medical benefits and permanent partial disability based on upon the afore-referenced evidence.

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOULESONG, MICHAEL
Employee/Petitioner

Case# **18WC007563**

OSWEGO FIRE PROTECTION DISTRICT
Employer/Respondent

On 2/25/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0507 RUSIN & MACIOROWSKI LTD
PATRICK J JESSE
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL MOULESONG
Employee/Petitioner

v.

OSWEGO FIRE PROTECTION DISTRICT
Employer/Respondent

Case # **18** WC **07563**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **New Lenox**, on **February 5, 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 _____

FINDINGS

On **February 21, 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 $**86,975.20**; the average weekly wage was $**1,672.60**.

On the date of accident, Petitioner was **45** 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 $**7,144.53** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injury which arose out of and in the course of his employment on February 21, 2018. The Arbitrator further finds that the Petitioner's right knee condition is causally related to the February 21, 2018 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$1,115.07 per week** for **11 weeks**, commencing **February 22, 2018 through May 10, 2018**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical **expenses contained in Petitioner's Exhibit 1**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$7,144.53** 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 **$790.64 per week**, the maximum allowable statutory rate, for **26.875 weeks**, because the injuries sustained caused the loss of use of **12.5% of the right leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **February 21, 2018** through **February 5, 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.

Moulesong v. Oswego Fire Protection Dist., 18 WC 07563

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

Signature of Arbitrator

February 21, 2020
Date

FEB 25 2020

STATEMENT OF FACTS

Petitioner testified he was employed by Respondent as a firefighter/paramedic and remains so employed. He works 24 hours on and 48 hours off. He testified that he was walking out of the station on 2/21/18 and was going to the apparatus floor, where the fire trucks are located, to join other firemen to go to the grocery store, and to training at another station. He had gone back inside to get the "kitty" money for shopping and was walking briskly back to the vehicle, where his coworkers were waiting. He testified that there is a step down that runs almost the length of the building that is necessarily encountered going from the building to the apparatus floor or vice versa. Petitioner testified that he traverses the step anywhere from a handful of times per day up to about 75 times per day, and hundreds of times per week. As he did so on 2/21/18, he testified he stepped down onto his right foot, twisted his knee and felt a pop. He noticed immediate pain that took him to the floor, and he needed help getting up. He was unable to bear weight without severe pain, and he was taken to Rush Copley Medical Center by ambulance.

Petitioner acknowledge that he had preexisting arthritis in the right knee but stated that he was not having any knee issues on 2/21/18 prior to the incident but had significantly more pain than he'd ever had before after the incident. He agreed he had undergone cortisone injections in the right knee in 2017 but had undergone no prior right knee surgeries.

The 2/21/18 ambulance run report from the Oswego Fire Protection District states that the Petitioner was "walking off step in bay floor, heard and felt a pop in his right knee" with immediate pain and inability to bear weight. He was unable to fully extend his leg in the ambulance. (Px2). At Rush Copley, the report stated Petitioner complained of right knee pain after stepping down an 8" step: "He reports on weight acceptance he felt the pain with a pop in his posterior knee." The triage report states: "states misstepped off step and injured knee." X-ray noted no fractures, dislocation or significant degenerative findings. He was prescribed crutches, a knee wrap and ibuprofen. He was to follow up with an orthopod. (Px2).

Petitioner testified he sought treatment with Dr. Burt at Midwest Sports Medicine Institute on 2/23/18, noting he had seen him previously for his knee. On 2/23/18, he complained of 8/10 right knee pain, and Dr. Burt noted: "there is no injury", however the report states he was walking to the truck bay at work and stepped down a 6" step and felt a pop in the posterior and lateral right knee with immediate pain that caused him to fall down. Petitioner indicated he had since been unable to bear weight. X-ray was normal. Dr. Burt diagnosed possible lateral and/or medial meniscus tear, prescribed a right knee MRI and took Petitioner off work. (Px3).

A right knee MRI was performed on 2/28/18 and was compared to 11/13/17 films. The findings were: 1) suggestive of radial tear at the body of the medial meniscus and increase in fraying of the posterior root of the medial meniscus, 2) mild sprain of but intact ACL, and 3) mild semimembranosus, mild popliteus and mild patellar tendinosis. (Px3).

On 3/2/18, Dr. Burt noted Petitioner continued to have moderate to severe medial, posterior and lateral knee pain and that he was unable to work. As the MRI showed a small medial meniscus tear, Dr. Burt recommended surgery involving partial meniscectomy and possible chondroplasty if needed, and he kept Petitioner off work. (Px3).

Surgery was performed by Dr. Burt on 3/14/18, which involved arthroscopic chondroplasty of the patella and medial femoral condyle, as well as partial medial meniscectomy. The post-operative diagnoses were grade III chondromalacia of the patella (extensive) and medial femoral condyle (moderate) and a small posterior horn medial meniscus tear. (Px3).

On 3/23/18, Petitioner reported he was improving and was not taking pain medication. He was to continue therapy and off work status. On 4/23/18, Petitioner was continuing improvement with therapy and continued to be held off work. He was advised to use a neoprene sleeve at work for any continuing pain. On 5/7/18, Dr. Burt returned Petitioner to full duty. (Px3). Petitioner testified he actually returned to work at the end of the month.

Petitioner attended therapy at Athletico from 3/20/18 to 5/18/18. The last report notes he had 27 visits, and that he had returned to work and working out without any pain. (Px4).

Respondent submitted a records review report of Dr. Karlsson from 5/25/19 into evidence. (Rx5). Dr. Karlsson reviewed the Petitioner's pre- and post-accident medical records, as well as the pre- and post-accident MRI films. Dr. Karlsson concluded that Petitioner had medial and patellofemoral arthritis and partial thickness tearing of the medial meniscus in his right knee, however he did not believe these diagnoses related to the work accident. He did not believe that stepping down a six to eight-inch step could cause a distinct injury or trauma to the knee. Dr. Karlsson noted that there was no description in the records of any pivoting, twisting, or fall. He further opined that the findings were all degenerative in nature and that Petitioner had similar complaints before the accident, including difficulty with stairs and pain with motion. Dr. Karlsson believed that the symptoms Petitioner experienced after the 2/21/18 accident were from the pre-existing degenerative changes in the right knee, rather than any type of new injury or condition. Dr. Karlsson did not believe the 2/21/18 accident caused, permanently aggravated, or accelerated the degenerative conditions. Dr. Karlsson ultimately concluded that Petitioner's pre-accident symptoms had returned with normal activity of daily living after the cortisone steroid injection had worn off. (Rx5).

On 5/29/18, Dr. Burt indicated Petitioner had completed therapy and had no pain, full range of motion and strength. He was released to a home exercise regimen and released to return to work and follow up as needed. (Px3). Petitioner testified that he believed it was at his last 5/29/18 visit with Dr. Burt when he was released from care and to full duty, and that 5/29/18 was his first shift back to work. He testified he hasn't returned to Dr. Burt or any other physician for right knee treatment since.

On 7/10/19, Petitioner's counsel forwarded Dr. Karlsson's report to Dr. Burt and requested his opinions in response, and the doctor indicated he disagreed with Karlsson and opined the 2/21/18 work injury aggravated the Petitioner's preexisting right knee condition and accelerated the need for surgery. He did not provide any explanation as to the basis of his opinions. (Px5).

Currently, Petitioner testified he has good days and bad days. On bad days his right knee is sore. The only medication he takes is ibuprofen, and he doesn't do this very often, maybe once every couple months. Noting he is a fireman, Petitioner testified his knee is sore on heavy training days, where he does a lot of crawling and climbing with lots of gear and equipment. He is able to perform his full work duties.

On cross examination, Petitioner acknowledged his prior right knee condition and agreed he saw Dr. Burt in November 2017 with right knee complaints. He did tell Dr. Burt at that time that walking and stair use would increase his pain, and that he had symptoms of swelling, tenderness and popping. He did not recall any discussion with Dr. Burt regarding a possible meniscal tear or surgery in December 2017, but he did undergo an MRI in November 2017 and had therapy and an injection but was not kept off work.

Respondent submitted photographs of the stair in question. Petitioner accurately testified that this is a long step that runs the length of the building. A ruler in one photo indicates the stair to be between 5 and 6 inches high. (Rx1). Petitioner agreed that the step shown in the photographs accurately depicts the one he stepped down from at Respondent's facility on 2/21/18, and that the ruler depicted indicates the step is approximately 6" above the apparatus floor, which he believed complies with building code. The floor is coated with a non-slick surface. Petitioner agreed there was no defect, debris or water in the location where he stepped down on 2/21/18. He reiterated that he was walking at a brisk pace when he fell but was not carrying anything or wearing any fire gear other than his station boots, which are steel-toed and required. He was not responding to an emergency at the time.

The Supervisor's Investigation Report of Lt. Roscoe is dated 2/21/18 and states that Petitioner was walking to Engine 2 on the apparatus floor and when he took the step down, he felt a pop in his right knee and was in instant pain with the inability to bear weight. Nature of injury was described as a hyperextension/sprain/strain. A separate witness report completed by Roscoe indicated he saw the incident while sitting in the fire truck, and Petitioner was "stepping down onto the main apparatus floor, leading with his right foot and saw him grimace. He was unable to put weight onto his right leg." (Rx2).

Lieutenant Roscoe testified on behalf of the Respondent. Petitioner's supervisor now and at the time of the alleged accident, Lt. Roscoe agreed Rx1 accurately depicted the step from the station house to the apparatus floor, and that there was nothing unusual about the step versus a typical step one would encounter throughout their day. The bay floor has a non-slip surface coating. He testified he was sitting in the officer's seat in the fire engine waiting for Petitioner on 2/21/18 and had a clear view of the Petitioner as he walked towards him when the incident occurred. He verified the Petitioner wasn't carrying anything and had no gear on outside of the standard uniform. He testified that Petitioner wasn't running but was walking briskly, though there was no emergency situation. He testified the Petitioner stepped down with his right foot and stood for a minute and didn't move. He didn't fall or trip. Lt. Roscoe didn't see any type of debris or defects in the area where Petitioner fell. He agreed with Petitioner that the number of times a firefighter encounters the step to the bay floor in a day varies, testifying this could be 0 to 75 times per day. Lt. Roscoe testified the Form 45 he completed states that Petitioner was walking to the apparatus floor with no further specificity. He agreed that they were preparing to go to the grocery store on 2/21/18, as they do every shift to buy food for the station house, but testified they were not also on their way to training that day.

With regard to Petitioner's preexisting condition, both parties submitted records from Dr. Burt and Athletico Physical Therapy. An 11/21/17 report from Athletico indicates Petitioner reported a one-month history of right knee pain with difficulty kneeling, using stairs and bending the knee. Following the 11/16/17 cortisone injection, he reported increased soreness. Some of Petitioner's prior medical records from Dr. Burt were submitted into evidence as well. On 11/9/17, Petitioner reported a five-week history of right knee pain (4/10), indicating it occurs intermittently and was worsening. He noted no injury but that he was a fireman and had pain

with workouts. X-ray was normal. Dr. Burt diagnosed a possible peripheral tear of the medial meniscus and wanted an MRI. The 11/9/17 intake form of Dr. Burt indicated complaint of pain and loss of flexibility, noted he injured it while working out approximately the last week of September. On 11/16/17, Petitioner reported intermittent medial/patella and posterior pain that was worse with stairs and kneeling. MRI was noted to show moderate CM patella but no definitive MMT or other pathology. The right knee was injected, and a few weeks of therapy was ordered. On 12/15/17, Petitioner reported significant improvement with injection and that he was doing fine at work and at home other than some soreness after workouts. The Arbitrator notes that an 11/13/17 note took Petitioner off work pending MRI, and on 11/16/17 he was released to full duty. (Px3; Rx3).

The 11/13/17 right knee MRI demonstrated: 1) shallow partial thickness cartilage loss at the lateral and patellofemoral compartments; 2) fraying at the posterior root of the medical meniscus; and, 3) small joint effusion with fraying at the free edge of the medial meniscus body. (Px3; Rx4).

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner sustained his burden of proof that he suffered an injury that arose out of and in the course of his employment with Respondent. Both elements, "arising out of" and "in the course of" must be shown in order for a claimant to establish a compensable accident under the Act. *McAllister v. Illinois Workers' Compensation Comm'n*, 2019 Il App (1st) 162747WC; 430 Ill.Dec. 434, 440 (2019).

"In the course of" refers to the "time, place, and circumstances under which the injury occurred." *Accolade v. Illinois Workers' Compensation Commission*, 990 N.E.2d 901 (2013). In the present case, the injury occurred at work while performing work duties. It is clear that the injury occurred in the course of the Petitioner's employment.

The requirement that the injury "arose out of" Petitioner's employment concerns the origin or cause of the claimant's injury. *Sisbro, Inc. v Industrial Comm'n*, 207 Ill.2d 193 (2003). The claimant must show that the injury "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.* at 203. The courts have found that there are three types of risks that an employee can be exposed to: employment risks, personal risks and neutral risks. *McAllister*, 430 Ill,Dec at 441. A risk is incidental to his employment when "it belongs to or is connected with what the employee has to do in fulfilling his duties." *Id.* The risk of injury to Petitioner in this case as a result of stepping off a step that runs the entire length of the bay floor when he was hurrying to get back to his colleagues who were waiting for him is incidental to his employment.

Lieutenant Roscoe testified that the firemen go to the grocery store every shift to buy grocery items for use in the fire department. He acknowledged that Petitioner was hurrying to get back after he had to go in the fire house to get the money used for the shopping. Such activity, in the Arbitrator's view, was incidental to his employment as it was regularly performed as part of the firefighter's on-the-job activities, and his supervisor was waiting for him in the fire truck. While Lt. Roscoe testified there was no emergency, he agreed that Petitioner was hurrying back to the truck with the shift kitty money.

The Arbitrator further finds that even if this activity was not considered an employment risk but a neutral risk, Petitioner has established he encountered this risk to a greater extent than the general public. A neutral risk is one that does not have any particular employment or personal characteristics. A neutral risk can be

compensable under the Act when a claimant is exposed to that risk to a greater degree than that of the general public. *McAllister*, 430 Ill.Dec. at 441. The risk can be increased either qualitatively or quantitively. Arguably, the Petitioner has established both.

The activity of stepping down from a step taken in isolation from the circumstances that surround it could be considered a neutral risk. However, in this instance, it was established that Petitioner was walking briskly by both his testimony and that of his lieutenant. He was walking briskly not for a reason personal to him but for the benefit of his employer. He was returning with the money needed in order to move forward with the grocery shopping for the day. Additionally, he established that he encounters this step more often than the general public encounters a step. He must traverse this step up to seventy-five times per shift, as confirmed by his supervisor. Finally, while the Arbitrator acknowledges that the height of the stair appears to be typical of stairs that the general public encounters, the step was nevertheless unusual in that it was not [part of a stairwell but rather ran the length of the building. The risk to Petitioner of injury from traversing this step is quantitively and qualitatively higher than that of the general public.

Therefore, taking all of the evidence together as a whole, the Arbitrator finds that the preponderance of the evidence establishes he suffered an injury that arose out of and in the course of his employment with Respondent.

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

The Arbitrator finds Petitioner's current condition of ill-being is causally related to the 2/21/18 accident.

While it was clear that Petitioner had a prior right knee condition and prior treatment to his right knee, that in and of itself is a not a bar to compensability. Petitioner had an MRI prior to the injury in November that did not show any medial meniscus tear, only mild fraying at the posterior root and the MRI taken directly after the injury in February showed findings suggestive of a radial tear in the body of the medial meniscus and increase in fraying in the posterior root of the medial meniscus. There was also an ACL sprain, which was a new finding. These findings were then confirmed during surgery.

Via a chain of events analysis, the Petitioner had been working full duty and traversing the stair numerous times between November 2017 and February 2018. When the incident occurred on 2/21/18, the Petitioner was immediately unable to bear weight and required emergency treatment. Petitioner's knee pain when he saw Dr. Burt in November of 2017 prior to the accident was 4/10 and intermittent, but when he returned to Dr. Burt following the 2/21/18 accident it had increased to 8/10 and he could not bear weight. The records of Dr. Burt at the time of his release of Petitioner in December 2017 indicated Petitioner was having no problems at work and having no issues.

The Arbitrator does not find the opinions of Dr. Karlsson to be tremendously persuasive. Dr. Karlsson did not examine the Petitioner in any way and never spoke to Petitioner directly about the mechanism of injury. There was also an ACL sprain, which was new and ignored by Dr. Karlsson. The Arbitrator notes that Dr. Burt opined that the injury accelerated Petitioner's condition, and his surgical recommendation supports this. Surgery was not mentioned as indicated following the November 2017 MRI.

Therefore, based on the above, the Arbitrator finds that the Petitioner established causation regarding his right knee condition.

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:

As the Arbitrator has already found that there was a compensable accident and causation, the Arbitrator finds that Petitioner's treatment following the 2/21/18 injury was causally related to the injury and reasonable and necessary to cure the effects of the injury. Dr. Karlsson did not dispute the necessity of treatment apart from causation, and the treatment allowed Petitioner to return to work full duty. Therefore, the bills related to this treatment are awarded. Respondent is liable for outstanding bills paid pursuant to the fee schedule and out of pocket expenses as documented in Px1. Respondent will receive a credit pursuant to Section 8(j) for payments made by Petitioner's group health insurance and will be required to hold Petitioner safe and harmless for any subrogation interest Petitioner's group health insurance may have.

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

According to Arbx1, the Petitioner is seeking TTD benefits from 2/22/18 through 5/10/18. Again, given that accident and causation has been found in Petitioner's favor, and he thereafter underwent right knee surgery, the period of TTD being claimed is reasonable and supported by the records of Dr. Burt. The Petitioner is entitled to TTD benefits from 2/22/18 through 5/10/18.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party has presented an AMA permanent partial impairment rating or report into evidence. Therefore, this factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a firefighter and has returned to his full work duties. He has continued to work full duty for almost two years since his May 2018 release. The Arbitrator gives this factor moderate weight in the permanency determination, as the injury did not result in any work restrictions.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Neither party has submitted evidence which would tend to show the impact of the Petitioner's age on his permanent condition relative to the accident. While the injury and surgery will likely result in increased degeneration over time, it is also true that the Petitioner clearly did not have a healthy knee prior to the accident. This factor also carries some weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was produced which would indicate that the 2/21/18 injury has resulted in a diminution of his earnings capacity. This factor carries reasonable weight in the permanency determination as well.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner's last medical report indicates he completed therapy, had no pain and full range of motion and strength. He was advised to continue a home exercise program and was released to full duty work and was to follow up as needed. His testimony indicated that he has ongoing knee soreness with heavier activities, but the Arbitrator would again note that the Petitioner was having some knee problems prior to the accident as well, and this is a factor in the permanency determination. This fifth factor carries the most significant weight in that determination.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 12.5% of the right leg pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC037310
Case Name	SZOT, BARBARA v. FRESH EXPRESS, INC.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0130
Number of Pages of Decision	20
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jason Carroll
Respondent Attorney	Brian Raterman

DATE FILED: 4/11/2022

/s/Marc Parker, 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

Barbara Szot,
Petitioner,

vs. No. 16 WC 037310

Fresh Express, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both parties herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, nature and extent of permanent disability, and penalties and fees, and being advised of the facts and law, corrects the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision, which is attached hereto and made a part hereof.

With regard to the identification of one of the examining doctors, Dr. Coleman, the Arbitrator identified the doctor as having been chosen by Respondent, when Petitioner had in fact selected Dr. Coleman to provide an opinion. The Commission finds that this was a clerical error and corrects the Decision to properly identify Dr. Coleman as an examiner chosen by Petitioner.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 31, 2021, is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner for reasonable and necessary medical services in the amount of $5,725.00 for services provided by Dr. Forys and $213.00 in reimbursement of her out-of-pocket expenses, pursuant to the fee schedule and as provided in Sections 8(a) and 8.2 of the Act

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits totaling $17,423.98, representing $401.21/week for 43-3/7 weeks, commencing November 23, 2016, through September 22, 2017, as provided in Section 8(b) of the Act. Respondent is entitled to a credit for TTD benefits paid in the amount of $17,423.98.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent and total disability benefits of $535.79/week for life, commencing September 23, 2017, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall 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.

April 11, 2022

/s/ *Marc Parker*
Marc Parker

mp/dak
o-4/7/22
068

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

/s/ *Carolyn M Doherty*
Carolyn M. Doherty

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC037310
Case Name	SZOT, BARBARA v. FRESH EXPRESS, INC.
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	17
Decision Issued By	Rachael Sinnen, Arbitrator

Petitioner Attorney	Jason Carroll
Respondent Attorney	Brian Raterman

DATE FILED: 8/31/2021

/s/Rachael Sinnen,Arbitrator

Signature

INTEREST RATE WEEK OF AUGUST 31, 2021 0.05%

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

BARBARA SZOT
Employee/Petitioner

v.

FRESH EXPRESS, INC.
Employer/Respondent

Case # **16** WC **37310**

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 **Rachael Sinnen**, Arbitrator of the Commission, in the city of **Chicago**, on **April 29, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 22, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**31,294.12**; the average weekly wage was **$601.81**.

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**17,423.98** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**14, 367.86** for other benefits, for a total credit of $**31,791.84**.

Respondent is entitled to a credit of $**12,691.81** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule and as provided in Sections 8(a) and 8.2 of the Act, of $5,725.00 directly to Petitioner for medical treatment provided by Dr. Forys and $213.00 directly to Petitioner to reimburse her out of pocket expenses.

Respondent shall pay Petitioner temporary total disability benefits totaling $17,423.98, which represents $401.21/week for 43 3/7 weeks, commencing November 23, 2016, through September 22, 2017, as provided in Section 8(b) of the Act. Respondent is entitled to a credit for TTD benefits paid in the amount of $17,423.98, which is equivalent to the full amount owed for TTD.

Respondent shall pay Petitioner permanent and total disability benefits of $535.79/week for life, commencing September 23, 2017 as provided in Section 8(f) of the Act. The weekly rate is the minimum permanent total disability rate for Petitioner's date of accident as outlined in Section 8(b)4 of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

August 31, 2021

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

Barbara Szot,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	Case No. 16 WC 37310
Fresh Express, Inc.,	)	
	)	
	)	
Respondent.	)	

FINDINGS OF FACT

This matter proceeded to hearing on April 29, 2021 in Chicago, Illinois before Arbitrator Rachael Sinnen on Petitioner's Request for Hearing. Issues in dispute include causal connection, past medical bills, temporary total disability ("TTD") including any potential overpayment of benefits made by Respondent, and permanent partial disability ("PPD"). (See Arbitrator's Exhibit "Ax" 1)

Barbara Szot ("Petitioner") testified in Polish with the assistance of a professional translator. (Transcript "T." p. 6-9). Respondent had its party representative, Joseph Domenic, present who worked as a environmental health and safety manager. (T. p. 4).

Petitioner's Job Duties

Petitioner was employed by Fresh Express, Inc. ("Respondent") as of November of 2016. She began working for Respondent in February of 2002. Petitioner worked at the Respondent's location in Streamwood, Illinois. (T. p. 11). She worked Monday through Saturday, 5:30 AM to 3:00 PM. (T. p. 12). Her job duties included cutting salad ingredients. (T. p. 11). Boxes of vegetables were brought to her workstation and she sliced them with a knife. (T. p. 14).

Accident of November 22, 2016

Petitioner testified that she was injured when she left her workstation to go to the restroom and stepped down from the wooden platform. As she did, her right foot got caught in the gap between the platform and a wall. She fell to the floor and hit her right leg and right arm on the floor. Supervisors were present at the time of the accident. (T. p. 15). Petitioner went home from work, but her husband then drove her to the hospital when her pain got worse. (T. p. 16). Prior to her work accident of November 22, 2016, Petitioner testified she never injured her right shoulder, right hip, or pelvis. (T. p. 42).

Summary of Medical Treatment:

Petitioner was admitted overnight at Presence Resurrection and was discharged the following day, on November 23, 2016. (T. p. 16; Petitioner's Exhibit "PX" 1). She complained of right shoulder pain, right hip pain, and groin pain. (PX1 p. 13). X-rays revealed a closed fracture of the greater tuberosity of her right humerus and a closed fracture of the right superior pubic ramus. The fractures were determined to be non-surgical. (PX1 p. 3, 16-18).

On November 23, 2016, Petitioner treated with Dr. Christopher Mahr at Northwest Orthopedics & Sports Medicine. (T. p. 17). Dr. Mahr confirmed her diagnosis of a fractured right inferior pubic ramus and closed nondisplaced fracture of the greater tuberosity of the right humerus. (PX3 p. 2).

Petitioner received home health care (including therapy) through Presence Home Health from November 2016 through January 2017. (T. p. 17; PX5).

On November 29, 2016, Petitioner's primary care physician, Dr. Victor Forys from Central Medical Clinic of Chicago, performed an in-home consultation. (T. p. 18). Dr. Forys assessed Petitioner with fractures of the right humerus, shoulder pain, fracture of the right superior ramus of the pubic bone, knee contusion and internal derangement, cervicalgia, and a trapezius muscle strain. He documented that these injuries were attributable to her fall at work. Dr. Forys noted Petitioner was to remain in bed as was unable to ambulate without assistance. (PX2 p. 2).

Petitioner returned to Dr. Mahr on December 13, 2016 at which point she was ambulating with a cane. Petitioner complained of right groin pain and right shoulder pain. Petitioner returned to Dr. Forys on December 27, 2016 with continued complaints of neck, shoulder, hip, knee, and groin pain. Petitioner was told to remain off work and continue in physical therapy. (PX3 p. 4).

On January 6, 2017, Petitioner was discharged from home healthcare services provided by AMITA Health Presence Home Care. (PX5 p. 39). Petitioner testified that when she was discharged from home healthcare on January 6, 2017 that she could perform only lighter household duties, but not everything. (T. p. 47).

On January 10, 2017, Petitioner returned to Dr. Mahr's office. He noted she was doing well, still ambulating with a cane, and had completed her home physical therapy. She continued to complain of "mild pain about the right shoulder and right hip." (PX3 p. 8). Dr. Mahr recommended she continue with outpatient physical therapy. He advised her to return to his office on an as-needed basis. (Id. at 9). He noted she may return to work as of January 24, 2017. (RX4 p. 7). Petitioner testified she did not return to work after Dr. Mahr returned her without restrictions. (T. p. 50). She confirmed at trial that she has not seen any orthopedic doctors aside from Dr. Mahr for treatment of her right shoulder or hip. (T. p. 46).

Petitioner testified she underwent outpatient physical therapy at Central Medical Clinic of Chicago. (T. p. 19; PX2 p. 28-68).

Petitioner returned to Dr. Forys in January, February, and March 2017 where she complained of pain in her shoulder, neck, hip, knee, and groin. Dr. Forys kept Petitioner off work, recommended physical therapy and ultimately ordered an MRI for the right shoulder. (PX11 p. 4-25).

On March 29, 2017 Petitioner underwent a right shoulder MRI at MRAD Golf Imaging Center. The final impression was a supraspinatus and subscapularis signal abnormality from tendinopathy, biceps tendon fraying from partial tear, glenohumeral joint narrowing and arthritis from mild degenerative joint disease and osteoarthritis and associated effusion and bursitis. (PX4 p. 3-4).

Petitioner returned to Dr. Forys on April 1, 2017 with severe weakness and fatigue. (PX 11, p. 26). She was admitted to Community First Medical Center that same day. (Respondent's Exhibit "RX" 8). A CT scan of Petitioner's abdomen and pelvis performed on April 2, 2017 showed an old fracture of the right pubic bone, a 10 mm cystic or lytic lesion at the right humeral head, and a large lytic lesion of the right iliac bone at the sacroiliac junction with metastasis or multiple myeloma considered. (RX8, p. 1085). On April 6, 2017, Petitioner was seen by Rachel Gross, PA, from Orthopedics. Petitioner reported a fall in November injuring her right shoulder and pelvis. It was noted that her fractures were healing well. Petitioner denied pelvic pain and reported walking normally without pain. (RX8, p. 1099). A progress note from Rachel Gross, PA, dated April 8, 2017 states that Petitioner was recommended to undergo open reduction and internal fixation of her left femur pending medical clearance. (RX8, p. 254). Petitioner was discharged on April 11, 2017 and her final diagnosis included multiple myeloma, clostridium difficile colitis, renal failure, hypercalcemia, and lytic lesions of the femur. It was noted that Petitioner would undergo surgery for the lytic lesion in the femur "at a later date as her condition improves to stand the surgery." (RX8 p. 4).

Petitioner received home healthcare from Presence as she was homebound and dependent on others for activities of daily living. She was discharged on April 19, 2017. (PX5 p. 40, 124, 135).

Petitioner returned to Dr. Forys on April 13, 2017. He noted she had recently been discharged from the hospital following a diagnosis of plasma cell myeloma. She continued to complain of pain in her right shoulder, neck, hip, and groin. Dr. Forys advised her to remain off work and to return in two weeks. She continued with physical therapy at Central Medical Clinic of Chicago while she also treated for plasma cell myeloma. (T. p. 21; PX2 p. 12, 48-69).

Petitioner returned to Dr. Forys on April 26, 2017 and May 3, 2017. Petitioner continued to complain of right shoulder, neck, hip, and groin pain. Dr. Forys' examination, assessment, plan, and work status were unchanged. (PX11 p. 30-41).

On May 17, 2017, Petitioner was seen by Dr. Joseph D'Silva at his office at the Illinois Bone and Joint Institute. It was noted that she was following up from her April hospital consultation. She reported no pain in either femurs or hips but used a cane for ambulation. On examination there was no hip irritability or pain to palpation. (RX5, p. 10).

Petitioner saw Dr. Forys again on May 17, 2017 where she was still describing weakness. (PX8 p. 44). That same day Petitioner returned to Community First Medical Center with shortness of breath and numerous x-rays were taken. (RX8 p. 1002-1029).

On June 15, 2017, June 28, 2017, July 26, 2017, and August 9, 2017, Petitioner saw Dr. Forys and no significant changes were documented in Petitioner's complaints nor in Dr. Forys' examination findings, assessment, plan, nor work status. (PX11, p. 50-76).

Petitioner underwent a CT scan of Petitioner's abdomen and pelvis on August 10, 2017. The lytic lesion with bone erosion in the right ilium was unchanged and the lytic lesions in the right surface pubis were also unchanged. (RX8 p. 1063).

Per Dr. Forys, Petitioner underwent a Functional Capacity Examination ("FCE") at Vital Rehabilitation on August 31, 2017. Diagnosis was right humerus fracture and right knee fracture. Patient Registration that was written in English, Polish and Spanish listed high blood pressure as the only illness. The therapist found both consistency of effort and reliability of pain. Petitioner demonstrated the ability to perform within the "sedentary" physical demand category which fell below her job's demand category of a packer, which is classified within the "medium" physical demand category. (RX10).

Petitioner continued to follow up with Dr. Forys on September 6, 2017, September 20, 2017, and February 17, 2018 with no substantial changes in examination findings, assessment, treatment plan or work status. (PX2 p. 23-25).

Petitioner was admitted again to Community First Medical Center in January 2018 with a diagnosis that includes congestive heart failure, renal insufficiency, multiple myeloma, and thrombocytopenia. (RX8 p.1155, 1236).

On July 10, 2018, Petitioner was examined by Respondent's Section 12 examiner, Dr. Matthew Colman. (T. p. 29). The Arbitrator notes that Petitioner moved to admit Dr. Colman's report into evidence but was rejected as hearsay at arbitration. (T. p. 112-114).

On March 11, 2019, Petitioner was examined by Respondent's Section 12 examiner, Dr. Ojash Bhagwakar. (T. p. 29). The Arbitrator notes that neither party moved to admit Dr. Bhagwakar's report.

Petitioner was admitted again to Community First Medical Center on November 25, 2019 with a diagnosis of pneumonia, pulmonary congestion, congestive heart failure, hypertension, multiple myeloma, debility, and neuromuscular weakness. (RX8 p. 1702).

Petitioner was hospitalized again at Community First Medical Center on December 6, 2019. Her diagnosis included pneumonia, multiple myeloma with chemotherapy, electrolyte abnormalities, congestive heart failure, GERD, elevated troponin, and debility. (RX8 p. 2390).

Dr. Forys drafted a letter dated November 4, 2020 confirming he is Petitioner's primary care physician. He stated that Petitioner reached maximum medical improvement ("MMI") for her work-related accident no later than her February 17, 2018 office visit. (PX2 p. 27).

Petitioner's Current Condition:

Since her work accident, Petitioner testified she has not sustained any new injuries to her right shoulder, right hip, or pelvis. (T. p. 42). Petitioner remains in remission from plasma cell myeloma. She never returned to work for Respondent or for any other employer. (T. p. 23-24). She testified she continues to suffer from a "pressuring pain" in her right shoulder. She continues to notice pain in her right hip as well. (T. p. 30-31). In regards to her right hip and pelvis, Petitioner testified she has to stop while going downstairs or even walking through her home because it, "…hurt so much I cannot continue going. I cannot just go roam around the room." (T. p. 34-35).

Deposition Testimony of Respondent's Section 12 Examiner, Dr. Shane Nho

On May 16, 2017, Petitioner was examined by Respondent's Section 12 examiner, Dr. Shane Nho. (T. p. 21). Dr. Shane Nho testified at the request of Respondent on October 23, 2017. (RX1). Dr. Nho is an orthopedic surgeon at Midwest Orthopaedics at Rush. He is board certified in orthopedic surgery and sports medicine and his specialties are arthroscopic and reconstructive surgery of the shoulder, hip, and knee. (RX1 p. 5-6).

At the time of Dr. Nho's examination, Petitioner localized her right hip pain to the lateral aspect of her hip, and she rated her pain at about a seven out of ten. (RX1 p. 8-11). While Petitioner's range of motion was similar bilaterally, Dr. Nho noted pain with rotation of her right hip with some pain around the peri trochanteric space. (RX1 p. 12). Dr. Nho noted a positive impingement test and positive Psoas impingement test. (RX1 p. 14). Dr. Nho read x-rays and CT images that confirmed healed inferior and superior fractures on Petitioner's pubic rami that he opined were related to Petitioner's work accident. (RX1 p. 21-22).

Dr. Nho opined that her ongoing subjective complaints of pain to the right hip were from the plasma cell lesions. (RX1 p. 21-25, 41, 71). Dr. Nho testified that Petitioner had reached MMI as her pubic rami fractures had healed. Dr. Nho felt that Petitioner could return to work as it pertained to her pubic rami fractures. (RX1 p. 25-26).

Dr. Nho explained that Petitioner had lytic lesions of the proximal mid right femoral diathesis and proximal left femoral diathesis. (RX1 p. 32). Lytic lesions are areas that show less density or less calcification, weakening the bones and making them prone to pain and fracturing. (RX1 p. 13-14, 32-33). Dr. Nho elaborated that there were also cancerous lesions in the ileum and the pelvis. (RX1 p. 37). The lesions in the right pubic ramus bone are within 5 centimeters of the fractures that are related to Petitioner's fall. (RX1 p. 19 – 24; 38). Dr. Nho testified that the lytic lesions could explain Petitioner's positive examination findings adding that weaker bones can elicit pain with rotational maneuvers. (RX1 p. 40-41).

Deposition Testimony of Respondent's Section 12 Examiner, Dr. Troy Karlsson

On June 26, 2017, Petitioner was examined by Respondent's Section 12 examiner, Dr. Troy Karlsson. (T. p. 21-22). Dr. Karlsson testified at the request of Respondent on November 6, 2017. (RX2). Dr. Karlsson specializes in orthopedic surgery and is board certified by the American Board of Orthopedic Surgeons. (RX2 p. 6).

Dr. Karlsson testified that Petitioner reported right shoulder pain on the outer aspect of the shoulder. (RX2 p. 13). Dr. Karlsson noted that Petitioner was using a cane with her right arm to stabilize herself. (RX2 p. 28-29). Dr. Karlsson testified that if Petitioner had significant problems with the right shoulder, he would expect her to hold the cane in her left hand to avoid putting pressure on the injured arm. (RX2 p. 29). Dr. Karlsson's physical examination of the right shoulder showed tenderness at the AC joint adjacent to the acromion and laterally to the greater tuberosity. Petitioner's range of motion and strength were symmetric. (RX2 p. 3-6; 16). There were no signs of dislocation or subluxation, negative impingement test and negative Speeds test. (RX2 p. 23-25).

Dr. Karlsson reviewed an x-ray the right shoulder taken on November 22, 2016 and interpreted it to show a nondisplaced fracture of the greater tuberosity of the humerus with the shoulder in good position and minimal arthritic changes. (RX2 p. 34). Dr. Karlsson defined the term "nondisplaced fracture" to mean a crack that was not out of place so the pieces of the fracture had not been moved relative to one another and the outline of the bone was in the same position it would have been before it was broken. (RX2 p. 34). Dr. Karlsson also reviewed the MRI of the right shoulder taken on March 29, 2017 and interpreted it to show mild arthritic changes at the AC joint and glenohumeral joint without any persistent fracture lines and no dislocations. He testified the rotator cuff was intact with mild increased signal of the supraspinatus but no tearing with an intact bicep tendon. (RX2 p. 35).

Dr. Karlsson opined that Petitioner's nondisplaced proximal humerus fracture had fully healed by March 29, 2017. (RX2 p. 38). While the fracture was causally related to her work accident, Dr. Karlsson opined that Petitioner's osteoarthritis was unrelated. (RX2 p. 41). He further testified that the treatment received by Petitioner for her right shoulder was reasonable and necessary, but no further treatment was needed. (RX2 p. 41).

Dr. Karlsson testified that Petitioner reported right knee pain with bruising and swelling, identifying the anterior aspect of the knee at her patella and just below her patellar tendon. (RX2 p. 13). Dr. Karlsson also examined Petitioner's hips to identify whether there was referred pain to the knee. He found normal hip motion. (RX2 p. 28). Dr. Karlsson opined that Petitioner's physical examination findings were negative bilaterally for meniscal tears or ligament damage. (RX2 p. 14-22). X-rays of her knees revealed arthritis in both. (RX2 p. 37).

In regards to her right knee, Dr. Karlsson's diagnosis was underlying osteoarthritis and a contusion, which had resolved. (RX2 p. 39). He testified the contusion was causally related to the work accident. (RX2 p. 41). He opined that her treatment for the knee was reasonable, necessary, and related to her work accident, but no additional care was needed. (RX2 p. 41-43). Dr. Karlsson opined that Petitioner was able to return to work at full duty relative to her injuries for the right

shoulder and right knee. (RX2 p. 43-44). He opined that the limitations outlined in her FCE were due to her non-work-related medical conditions, including her pulmonary status, cancer, and renal failure. (RX2 p. 60-61).

Deposition Testimony of Respondent's Section 12 Examiner, Dr Wellington Hsu

On May 15, 2017, Petitioner was examined by Respondent's Section 12 examiner, Dr. Wellington Hsu. (T. p. 21). Dr. Hsu testified by evidence deposition on October 30, 2017. (RX3). Dr. Hsu practices medicine at Northwestern Memorial Hospital as a board-certified orthopedic spine surgeon. (RX3 p. 5-6).

Dr. Hsu testified that Petitioner provided him with a history of falling from a platform at work and reported having right hip pain, right shoulder (and forearm) pain, and neck pain. (RX3 p. 10-12). Dr. Hsu's physical examination of the lumbar spine was normal in terms of motion, provocative signs, and Waddell testing. He testified his cervical spine examination demonstrated a range of motion that was normal for a 65-year-old with negative provocative maneuvers including Spurling sign, Lhermitte and Hoffman's sign. (RX3 p. 13). Dr. Hsu explained that the Spurling tests re-creates radiculopathy into the arm. (RX3 p. 14). He elaborated that Lhermitte's sign was a test for cervical cord compression that would be positive if there was pain radiating down the neck. (RX3 p. 14). Dr. Hsu admitted that forearm and shoulder pain could be consistent with cervical radiculopathy. (RX3 p. 12).

Dr. Hsu confirmed that he did not have any diagnostic films to review when forming his opinions. (RX3 p. 17-18). He concluded Petitioner sustained a cervical strain as a result of her work accident of November 22, 2016. (RX3 p. 18). He opined that the treatment she received for her cervical injury during the six weeks following her accident was reasonable, necessary, and related to the accident. (RX3 p. 23). He indicated she could return to work full duty as it pertained to her cervical injury. (RX3 p. 25). He testified that the limitations outlined in her FCE were in no way related to her cervical spine and was likely the result of her diagnosis of multiple myeloma. (RX3 p. 32).

Deposition Testimony of Respondent's Section 12 Examiner, Dr Samer Attar

On May 30, 2019, Petitioner was examined by Respondent's Section 12 examiner, Dr. Samer Attar. (T. p. 29-30). Dr. Attar testified by evidence deposition on September 5, 2019. (RX6). Dr. Attar is a board-certified orthopedic surgeon with a specialty in oncology at Northwestern. He mainly deals with patients with bone and soft tissue tumors, both benign and malignant. (RX6 p. 5-7).

Dr. Attar was given a history of a work accident on November 22, 2016 when Petitioner fell from a platform. (RX5 p. 13-14). Petitioner presented to Dr. Attar with persistent pain in her right shoulder, difficulty lifting her right arm above her head, and reported being unable to walk long distances due to anterolateral right hip pain. (RX6 p. 14-15). Dr. Attar's physical examination revealed an antalgic gait over the right lower extremity, limited range of motion of her right shoulder, and tenderness over her right hip. He did not find any pertinent findings in her left upper extremity or left lower extremity. (RX6 p. 16).

Dr. Attar testified he reviewed the images taken in his office which revealed a radiolucent lesion in her right proximal femoral diaphysis that was compatible with her history of myeloma. (RX6 p. 23-24). Dr. Attar explained that a radiologic lesion is a dark spot on the bone, which indicates a tumor occupying normal bone marrow. He also viewed a callus around her right superior and inferior pubic ramus, which was compatible with her old healed fracture, but no pathologic lesion. (RX6 p. 24-25; 31). Dr. Attar opined that the healed fracture was near her right groin and not where she displayed her pain location on her right hip. (RX6 p. 25-26).

While he did not feel the area of her hip pain directly correlated with the area of these fractures, Dr. Attar opined that her myeloma lesions did not impact her physical function with regards to her right shoulder or right hip. (RX6 p. 31-32, 48). Dr. Attar further testified that he did not find evidence that the right shoulder and right hip pain were coming from abnormalities in the bone as result of myeloma. (RX 6 p. 34). While Dr. Attar explained he focused his evaluation mainly on the orthopedic oncologic aspects of her care, he stated that her healed fractures could have impacted her physical function at the time he examined her. (RX6 p. 31-32, 41). Although Dr. Attar testified that multiple myeloma has negative ramifications for overall health that could impact her physical function, he testified that Petitioner's pain and FCE results could be related to her work accident. (RX6 p. 34, 40-41). Dr. Attar stated that healed fractures can continue to cause pain and it was possible that Petitioner's ongoing pain in her right shoulder and difficulty lifting her arm above her head was consistent with the mechanism of her work accident. (RX6 p. 41-43).

Deposition Testimony of Petitioner's Treating Doctor, Dr. Victor Forys

Dr. Victor Forys testified at the request of Petitioner on September 3, 2020. (PX9). Dr. Forys is board certified in internal medicine and is a member of the American Association of Orthopaedic Medicine and the American College of Occupational and Environmental Medicine. (PX9 p. 6-7). His practice includes the treatment of adults for a variety of illnesses as well as a practice that focuses on the treatment of patients who have been injured in the workplace and in car accidents. (PX9 p. 7).

Dr. Forys testified that he has been Petitioner's primary care physician since she first presented to him for injuries sustained in her work accident of November 22, 2016. (PX9 p. 8). Dr. Forys testified that he stopped treating Petitioner for work related injuries on February 17, 2018, but she continued to follow up with him for a variety of medical issues. (PX9 p. 28-29).

The most recent office visit of Petitioner prior to Dr. Forys' deposition was on August 15, 2020. (PX9 p. 30). At that visit, Petitioner continued to have hip pain, knee pain, limping, neck pain, and shoulder pain. (PX9 p. 30-31). Dr. Forys opined that Petitioner's current condition of ill-being as it related to her right hip was related to her work accident of November 22, 2016. (PX9 p. 31). He further opined that her right knee pain, neck pain, and right shoulder pain were also directly related to the injuries she sustained in her work accident. (PX9 p. 31-32). Dr. Forys explained that Petitioner's pain issues never went away after her accident as she was suffering from post-traumatic arthritis. (PX9 p. 32-33). Dr. Forys opined that Petitioner is no longer able to perform her prior work duties as a result of the injuries she sustained in her November 22, 2016 accident. (PX9 p. 33).

Dr. Forys confirmed that Petitioner suffered from congestive heart failure, resulting in shortness of breath and fatigue. He admitted that Petitioner's congestive heart failure would have an effect on her physical stamina and strength. (PX9 p. 70). Dr. Forys testified that, at the time of the FCE, Petitioner was acutely ill in terms of heart failure and multiple myeloma, which affected her performance at the FCE. (PX9 p. 82).

Deposition Testimony of Vocational Counselor Laura Belmonte

Laura Belmonte testified at the request of Petitioner on March 4, 2021. (PX10). She testified that she began working for Vocamotive in 2013. At that time, her position was that of a "job developer," which she indicated involved meeting with clients five days per week to assist them in their job searches. She began working as a counselor in 2017 at Vocamotive by working underneath more senior counselors. In 2019, she graduated from Northern Illinois with a master's degree in rehabilitation counseling. Once she graduated, she began working on her own as a vocational counselor at Vocamotive. (PX10 p.6-8).

Ms. Belmonte testified she interviewed Petitioner by telephone on January 18, 2021. (PX10 p. 9). She testified that this meeting was completed at the request of Petitioner's attorney to provide her opinions regarding Petitioner's employability. (Id.). Following her telephonic meeting with Petitioner, she drafted a report dated January 29, 2021. (Id. at 9-10).

At the request of Petitioner's counsel, Ms. Belmonte met with Petitioner over the phone with a Polish interpreter on January 18, 2021 for a vocational evaluation. Ms. Belmonte drafted a report after her meeting dated January 29, 2021. (PX10 p. 9-10; Deposition "Dep" Exhibit 2).

In her report, Ms. Belmonte outlined documents she reviewed in preparation of drafting her own report. These documents included various medical records as well as another vocational evaluation completed by former Vocamotive employee, Lisa Helma, in 2018. (PX10 p. 11-12). Ms. Belmonte testified she never reviewed a job description for Petitioner's role with Fresh Express. (PX10, p. 66). Ms. Belmonte testified she is unaware of any efforts made by Petitioner to find new employment since her alleged accident date. (PX10 p. 10-15).

Ms. Belmonte testified she took a history from Petitioner as part of her interview. She noted Petitioner was sixty-nine years old at the time of her interview and was born in Poland on January 30, 1952. Petitioner reported having permanent work restrictions as outlined in the FCE completed on August 31, 2017. Ms. Belmonte was also aware of Petitioner's history of myeloma. Petitioner reported she had since recovered from myeloma and her other medical issues of heart and kidney failure were under control through the use of medications. Petitioner also advised Ms. Belmonte that she uses a cane or walker to ambulate, which assists with stability. (PX10 p. 13-14).

Ms. Belmonte testified regarding Petitioner's ability to perform activities of daily living. She indicated Petitioner was independent with toileting and showering, however, her husband does assist her with getting into and out of the shower. Her husband also assists her in dressing. Petitioner does not do any grocery shopping due to her mobility issues and relies instead on her

husband. She avoids household chores such as vacuuming, cleaning windows, and dusting due to pain. She does perform light meal preparation. (PX10 p. 15-16).

Petitioner advised Ms. Belmonte that she completed eight years of school and three years of culinary training in Poland before moving to the United States. She did not, however, complete the culinary training. She does not have the equivalent of a high school diploma. Petitioner cannot read or write in English. In regards to her computer proficiency, Petitioner advised Ms. Belmonte that she has essentially never even touched a computer in her life. The only paper job application she has ever completed was for Respondent. (PX10 p. 24).

Ms. Belmonte took a vocational history from Petitioner dating back to her time living in Poland. Prior to working at Respondent, she worked as a hand packager in which she packed bicycle parts into boxes from 1997-2003. From 1994-1997, she cleaned people's homes. In Poland, from approximately 1972 – 1992, she worked as a hand packager at a paper factory packing toilet paper and other products into boxes. She worked in a kitchen for a couple of years prior to the toilet paper position. Ms. Belmonte concluded that Petitioner has only ever worked in unskilled or low semiskilled jobs. As a result, Ms. Belmonte opined that Petitioner did not obtain any transferable skills through her prior work experiences. (PX10 p. 26-27).

Taking into consideration factors of Petitioner's advanced age, low education, poor English skills, unskilled work history, low functional capacities, and little transferable skills, Ms. Belmonte concluded that Petitioner is not alternatively employable. (PX10 p. 44).

CONCLUSIONS OF LAW

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

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972).

It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010).

In the case at hand, the Arbitrator observed Petitioner during the hearing. While she testified with the use of a Polish interpreter, she was soft spoken and polite. She did not appear to understand

any English relying heavily on her interpreter including courtroom instructions such as where to sit. Petitioner did use her right hand and arm while talking to gesture, extending her arm fully in front of her and to her side. However, she never extended her arm above shoulder level. While the Arbitrator observed Petitioner walking slowly and cautiously, the Arbitrator did not see Petitioner use a cane or walker.

Petitioner appeared to be generally confused and she is a poor historian when it comes to her medical condition and past treatment. On cross examination, Petitioner denied not feeling well from August 2017 to January 2018 despite her hospitalizations. (See T. p. 79-82). She denied having bone lesions in her legs or discussing surgery on her left leg. (See T. p. 74). Petitioner testified that she did not feel fatigued during chemotherapy or feel any pain (other than her right shoulder and right hip pain). (See T. p. 77-78). The Arbitrator cannot rely on Petitioner's testimony about her medical history and medical condition. Instead, the Arbitrator relies on the medical records submitted into evidence.

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

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. 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. Even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." International Harvester v. Industrial Com., 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982).

It is evident that Petitioner sustained a fractured right inferior pubic ramus and a closed nondisplaced fracture of the greater tuberosity of the right humerus as a result of her work accident. In addition to the fractures, Petitioner was assessed for a knee contusion, cervicalgia, and right shoulder tendinopathy, biceps tendon fraying from partial tear, and osteoarthritis all of which Dr. Forys attributed to her fall at work. In regards to the neck, Respondent's Section 12 examiner, Dr. Hsu concluded Petitioner sustained a work-related cervical strain that had resolved within six weeks. In regards to her right knee, Respondent's Section 12 examiner, Dr. Karlsson, opined that Petitioner's contusion was related to her work injury and had resolved.

The crux of this case rests on whether Petitioner's ongoing complaints of pain and functional limitations are causally related since her fractures healed (especially the right pubic ramus fracture in light of the April 2017 findings of lesions at the right humeral head and right iliac bone).

Respondent's Section 12 examiner, Dr. Nho, is board certified in orthopedic surgery. Dr. Nho opined that Petitioner's pubic rami fractures had healed and that any ongoing hip pain was from

her lesions. However, Respondent's other Section 12 examiner, Dr. Attar is a board-certified orthopedic surgeon *with a specialty in oncology*. The Arbitrator places great weight on the testimony and opinions of Dr. Attar because his qualifications make him best suited to render opinions about the correlation between Petitioner's condition, her fractures, and her myeloma. The Arbitrator finds it significant that Dr. Attar stated Petitioner's myeloma lesions *did not* impact her physical function with regards to her right shoulder or right hip. (See RX6 p. 31-34, 48). When asked about whether the area of her hip pain correlated with the area of her healed fractures, Dr. Attar testified, "[w]here she was just having pain isn't really the typical location where I would expect somebody with a pubic ramus fracture that's healed…" However, he further stated that it was "possible, but I can't say definitively." (See RX6, p. 32). He also stated that healed fractures *can* continue to cause pain and *could have* impacted her physical function at the time he examined her as well as at the time of the FCE. (See RX6 p. 31-32, 41-43). Petitioner's primary doctor, Dr. Forys, did relate Petitioner's ongoing shoulder and hip pain to the work accident and finding Petitioner unable to return to her former employment based on the FCE.

It is obvious that during her treatment Petitioner became acutely ill struggling from numerous ailments including heart failure and multiple myeloma. However, Dr. Forys continued to document ongoing complaints for her work-related injuries until she reached MMI on February 17, 2018. Moreover, Dr. Attar did not dismiss the possibility that Petitioner's healed fractures could be the source of her pain and ongoing physical limitations. Petitioner need not show that her work injuries are the sole cause, "but for" cause, or primary cause of her weakened condition. Petitioner only needs to show that her work injuries are *a* causative factor. See Sisbro, Inc., 207 Ill. 2d at 205. The Arbitrator finds that Petitioner has met her burden and finds Petitioner's current condition of ill-being is causally related to the injury

Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Having found that Petitioner's condition of ill being is causally related to her work accident, the Arbitrator also finds Petitioner's past medical treatment to be reasonable and necessary and finds that Respondent has not paid for said treatment.

The outstanding medical charges include $5,725.00 from Dr. Forys plus an additional $213.00 representing Petitioner's out of pocket expenses. Petitioner's out of pocket expenses include a payment to Presence Resurrection Medical Center in the amount of $163.00 for her initial visit on the date of accident and $50.00 for treatment provided by Dr. Mahr. (See Px 6).

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule and as provided in Sections 8(a) and 8.2 of the Act, of $5,725.00 directly to Petitioner for medical treatment provided by Dr. Forys, and $213.00 directly to Petitioner to reimburse her out of pocket expenses.

Issue K, whether Petitioner is entitled to any temporary total disability benefits, the Arbitrator finds as follows:

Petitioner claims to be entitled to temporary total disability benefits from November 23, 2016, through September 22, 2017, which represents a period of 43 3/7 weeks. Respondent disputes only the period from June 28, 2017, through September 22, 2017, contesting causation. (See Ax 1.)

Having found that Petitioner has met her burden regarding causation as well as the reasonableness and necessity of treatment, the Arbitrator finds that Petitioner is entitled to TTD benefits. The Arbitrator finds Respondent liable for 43 3/7 weeks of TTD benefits (November 23, 2016 through September 22, 2017) at a weekly TTD rate of $401.21. Respondent is entitled to a credit for TTD benefits paid in the amount of $17,423.98, which is equivalent to the full amount owed for TTD.

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

A person is permanently and totally disabled when he or she cannot perform any services except those for which no reasonably stable labor market exists. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 487 (1979). A claimant need not show she has been reduced to total physical incapacity before being entitled to a permanent and total disability award. *Interlake, Inc. v. Industrial Commission*, 86 Ill. 2d 168, 176 (1981). In addition, where any employee's disability is limited in nature so that she is not obviously unemployable or if there is no medical evidence to support a claim of permanent total disability, the burden is on the employee to establish by a preponderance of the evidence that she falls into the "odd lot" category, "that is, one who, although not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market." *Westin Hotel v. Illinois Workers' Compensation Commission*, 372 Ill. App. 3d 527, 544 (2007).

A claimant may establish she is permanently and totally disabled under the odd lot theory by showing that: (1) considering her age, education, skills, training, physical limitations and work history she would not be regularly employable in any well-known branch of the labor market or (2) following a diligent job search, she was unable to find gainful employment. When a claimant makes a prima facie case showing that she falls into the odd lot category, the burden shifts to the employer to show that a reasonably stable job market nevertheless exists for that employee. See *Kula v. A.E.R.O Special Education Cooperative*, 18 I.W.C.C. 0705 (November 19, 2018).

Laura Belmonte testified that Petitioner was not an ideal candidate for vocational services. Ms. Belmonte explained that Petitioner's advanced age, the significant gap in her employment, her limited skillset, limited education, and her inability to communicate in the English language would be considered liabilities to prospective employers. As a result, Ms. Belmonte concluded Petitioner would not be suitable for any stable employment. Petitioner's physical restrictions impeded any transferability of her past relevant skill sets and are significant obstacles impeding Petitioner's ability to secure alternative employment. The Arbitrator concludes that Petitioner met her burden of a prima facie case of permanent total disability. Respondent offered no contrary evidence to indicate a stable labor market exists for Petitioner.

Wherefore, having found that Petitioner has met her burden regarding causation and has established a prima facie case for permanent total disability that was unrebutted, the Arbitrator finds that Respondent shall pay Petitioner permanent total disability benefits of $535.79/week for life, commencing September 23, 2017, as provided in Section 8(f) of the Act. The weekly rate is the minimum PTD rate for Petitioner's date of accident as outlined in Section 8(b)4 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.

Issue M, whether penalties or fees should be imposed upon Respondent, the Arbitrator finds as follows:

The Arbitrator declines to impose penalties or fees upon Respondent as the Arbitrator finds Respondent's reliance upon the combined opinions of its Section 12 examiners to be in good faith.

It is so ordered:

Arbitrator Rachael Sinnen

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC011122
Case Name	CREDIT, MICHAEL v. AMERICAN RED CROSS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0131
Number of Pages of Decision	13
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	David Martay
Respondent Attorney	Rory McCann

DATE FILED: 4/11/2022

/s/Marc Parker, 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

Michael Credit,

Petitioner,

vs. NO: 12 WC 11122

American Red Cross,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 30, 2021, 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.

April 11, 2022

MP:yl
o 4/7/22
68

/s/ *Marc Parker*
Marc Parker

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC011122
Case Name	CREDIT, MICHAEL v. AMERICAN RED CROSS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	10
Decision Issued By	Charles Watts, Arbitrator

Petitioner Attorney	David Martay
Respondent Attorney	Rory McCann

DATE FILED: 4/30/2021

/s/ Charles Watts, Arbitrator
Signature

INTEREST RATE WEEK OF APRIL 27, 2021 0.03%

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

Michael Credit
Employee/Petitioner

v.

American Red Cross
Employer/Respondent

Case # **12** WC **11122**

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 **Charles Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **March 15, 2021,** after reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☒ TTD

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other:

FINDINGS

On **December 22, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$15,218.43**; the average weekly wage was **$427.50**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **4** dependent children.

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

Respondent shall be given a credit of $**26,258.56** 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 $**90,475.05** under Section 8(j) of the Act.

ORDER

Medical Causation: The Arbitrator finds Petitioner has proven by a preponderance of the evidence that his current conditions of ill-being to his cervical spine, including all three surgeries, as well as his left elbow and left elbow surgery related to his work injury on December 22, 2011.

TTD: The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from December 25, 2011 through December 15, 2016. This represents 261 and 1/7th weeks of disability at a rate of $330.00 totaling $86,176.86. Respondent is due a credit of $26,258.56.

Medical Bills: Respondent shall be responsible for the following medical bills: Blue Cross Blue Shield of Illinois – $65,176.18, Arthritis Treatment Center of the Low Country – $1,814.72, Low Country Spine and Sports – $1,023.00, Elmhurst Neuroscience Institute – $2,571.00, Achieve Manual Physical Therapy--$29,905.00, Connexus Pharmacy--$254.00, CVS--$2,372.68.

Permanency: The Arbitrator finds Petitioner sustained a permanency loss of 40% man as a whole pursuant to Section 8(d)(2) of the Act and 20% loss of use of the left arm pursuant to Section 8(e) of the Act. This award amounts to 250.6 weeks of permanency at the rate of $330.00 totaling $82,698.00.

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

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

Signature of Arbitrator

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL CREDIT	)	
	)	
Petitioner,	)	
	)	
v.	)	**No. 12 WC 11122**
	)	
AMERICAN RED CROSS	)	**Honorable Charles Watts**
	)	
Respondent.	)	

FINDINGS OF FACT

On December 22, 2011 Petitioner was employed by the American Red Cross as a phlebotomist. (Tr. 9) As part of his job for the Respondent, Petitioner would drive a truck, set up blood drives, draw blood and pack up and process blood. (Tr. 10). On the above-mentioned date, Petitioner stated that he was unloading the truck, picked up a dolly and felt a burn down the back of his neck into his shoulder. (Tr. 10).

Petitioner reported to the emergency room at Rush University Medical Center. (Px. 4). The doctors recommended he have an MRI done of the cervical spine. The MRI revealed a prior cervical fusion for the levels C5 through C7 which had been performed approximately one year prior. *Id.*

On January 20, 2012 Petitioner reported to Occupational Health Services with complaints of neck and left shoulder pain. (Px. 9) He was prescribed physical therapy and given a work restriction of no use of the left arm. He was also ordered not to operate the company vehicle.

On March 6, 2012 Petitioner came under the care of Dr. Couri with Elmhurst Neuroscience. (Px 10). Petitioner had an epidural injection at the C8 level and began a course of physical therapy at Achieve Physical Therapy. (Px. 21).

On June 7, 2012 Petitioner reported to Dr. Dixon with complaints of neck and left arm pain. Dr. Dixon prescribed a cervical fusion. (Px 10) On July 20, 2012 Dr. Dixon performed an anterior cervical discectomy and fusion at the C7 through T1 levels. *Id.*

On August 26, 2013 Petitioner reported to Dr. Ryan Hennessy for an evaluation of his left shoulder and elbow. (Px. 17). On September 26, 2013 Dr. Hennessy performed a left elbow ulnar nerve transposition. After ongoing additional testing including EMG's performed in February 2014, Petitioner began a course of physical therapy at Achieve Physical Therapy for his left elbow. (Px. 21)

Dr. Hennessy referred Petitioner for treatment with a pain management specialist, Dr. Najera. Dr. Najera saw Petitioner on May 20, 2014 and on June 17, 2014 and was prescribed additional physical therapy for the cervical spine. (Px. 15). Petitioner was released to full duty work with respect to his left elbow by Dr. Hennessy on July 11, 2014. (Px. 17).

Petitioner returned to Dr. Najera on July 15, 2014 with continued neck pain and Dr. Najera referred Petitioner back to Dr. Couri for additional evaluation. (Px. 15, 16). On September 10, 2014 Petitioner underwent an epidural steroid injection into a cervical spine performed by Dr. Couri. Petitioner had another cervical epidural steroid injection performed on September 23, 2014. (Px. 10).

Petitioner saw Dr. Dixon on October 16, 2014 and prescribed a repeat MRI of the cervical spine. Petitioner returned to Dr. Couri with the result of the cervical spine MRI on November 20, 2014 at which time additional injections were prescribed. Dr. Couri also continued to authorize Petitioner off work. (Px. 10).

After a follow up evaluation with Dr. Najera on January 27, 2015 Petitioner was referred for an evaluation with Dr. Koutsky due to continued left sided neck pain. (Px. 15, 13). Dr. Koutsky prescribed a Tens unit and also ordered additional EMG studies. Petitioner returned to Dr. Koutsky on March 12, 2015 and recommended a repeat EMG. Petitioner returned to Dr. Koutsky on March 16, 2015 to review the EMG at which time he was referred back to Dr. Najera for additional pain management treatment. Petitioner next saw Dr. Koutsky on April 16, 2015 and was prescribed additional cervical spine physical therapy, treatment with the pain clinic and a repeat MRI of the cervical spine. Dr. Koutsky continued to authorize Petitioner off work. (Px 13). Petitioner underwent another MRI of the cervical MRI performed at Elmhurst Open MRI on April 24, 2015. He was discharged from physical therapy on May 14, 2015. On referral from Dr. Najera, Petitioner sought treatment with Dr. Patel on May 19, 2015 due to continued neck pain. (Px. 15, 16). Dr. Patel recommended Petitioner return to Dr. Dixon for further evaluation. Dr. Dixon recommended additional surgery and a cervical fusion was performed by Dr. Dixon on September 22, 2015. (Px. 10).

Petitioner remained under the care of Dr. Najera for additional follow up pain management treatment in October 2015. Due to continued pain, Petitioner underwent a third cervical surgery with Dr. Dixon on November 22, 2015. (Px 22). The surgery involved a posterior cervical laminectomy and foraminotomy at C4 and C5 through C6 and C7 levels. Post-surgery, Petitioner began another course of physical therapy at Achieve Physical Therapy. (Px. 21).

Petitioner continued under the care of Dr. Najera through 2016 with monthly follow ups. (Px. 15, 16). On December 15, 2016 Petitioner saw Dr. Dixon and he was discharged from medical care with a permanent 20-pound lifting restriction. (Px 23). Petitioner returned to Dr. Najera on December 29, 2016 and it was recommended he seek an evaluation with a neurologist.

On September 21, 2017 Petitioner reported to Dr. Cramer a neurologist in South Carolina. (Px 20). Additionally, Petitioner testified that he began employment with Walmart in January 2017. Petitioner saw Dr. Cramer on September 21, 2017 and additional physical therapy was prescribed for his cervical spine pain. Petitioner then began a course of physical therapy at Corner Stone Physical Therapy as well as Achieve Manual Physical Therapy. (Px. 19, 21).

Petitioner saw Dr. Cramer in March, 2018 and was prescribed a repeat MRI of the cervical spine. (Px. 20). Petitioner had an MRI performed on April 3, 2018. Petitioner returned to Dr. Cramer

for an evaluation on May 6, 2018 at which time they were prescribing additional physical therapy due to shoulder pain. Dr. Cramer also referred Petitioner to Dr. Batson for injections into the neck.

Petitioner saw Dr. Batson on April 26, 2018 as well as May 2, 2018 and provided a course of cervical facet injections. (Px. 5). Petitioner next saw Dr. Batson on June 14, 2018 and he was recommending nerve blocks or additional trigger point injections. On August 21, 2018 Petitioner reported to Dr. Cramer and underwent another course of trigger point injection into the neck. (Px. 20). Petitioner underwent additional cervical injections on September 7, 2018 and September 26, 2018. Petitioner remained under the care of Dr. Cramer and saw him again on July 10, 2019. Dr. Cramer provided another care of cervical trigger point injections and continued Petitioner with permanent 20 lb lifting restriction.

Petitioner remained under the care of Dr. Cramer with his final evaluation on March 21, 2020 at which time the doctor was recommending additional trigger point injections and medications. (Px. 20).

At hearing, Petitioner testified that he was entitled to temporary total disability benefits from the time of his accident until his return to work for Walmart in South Carolina on January 2, 2017. Petitioner testified he is employed as an overnight team leader. (Tr. 29). His current job with Walmart is supervisory in nature, making schedules and overseeing operations overnight. The job he is performing is within his permanent 20-pound lifting restriction. (Tr. 30).

Petitioner testified he continues to have pain in his neck and left shoulder. (Tr. 31-32). Petitioner described the pain as sharp, dull, aching pain that he notices almost every day. Petitioner complained of stiffness in his left shoulder and into his left elbow. He occasionally has tingling down into his left fingers. (P32). Petitioner testified he does not feel comfortable driving a car, although he does not have restrictions from his doctors in that regard. (Tr. 32-33). Petitioner remains on Norco, and also takes Morphine and Tizanidine. (P33).

On cross-examination Petitioner testified that when he was hired at Walmart he was originally hired as a produce stocker. (Tr. 36). Petitioner testified however that his job was still within his restrictions because the employer was willing to accommodate him. (Tr. 36). On cross examination, Petitioner confirmed he underwent prior cervical fusion approximately one year prior to his pending workers' compensation injury. Petitioner underwent prior cervical fusion according to his testimony and he last treated with Dr. McCall on March 21, 2011. (Tr. 44-45).

CONCLUSIONS OF LAW

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

To obtain compensation under the act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980)) including that the accidental injury both arose out of and occurred in the course of his employment (Horvath v. Industrial Commission, 96 Ill.2d. 349 (1983)) and that there

is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, I29 Ill. 2d 52, 63 (1998).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972).

While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980). The mere existence of testimony does not require its acceptance. Smith v. Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. U.S. Steel v. Industrial Commission, 44 Ill2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill. App. 3d 284, 574 N.E.2d 1244 (1991). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010).

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be a credible witness. Petitioner did not appear uneasy in his seat while testifying nor while observing the hearing. At all times, including cross examination, he remained calm. Petitioner's answers were forthright, and his tone of voice remained consistent. Petitioner's physical mannerisms were appropriate and evinced sincerity.

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

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. R & D Thiel v. Workers' Compensation Comm'n, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n, 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or

even the primary factor of an injury, as long as it is a causative factor. Sisbro, Inc. v. Indus. Comm'n, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." Int'l Harvester v. Industrial Comm'n, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. Schroeder v. Ill. Workers' Comp. Comm'n, 79 N.E.3d 833, 839 (Ill. App. 4th 2017). A prior condition followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of an accident. Spector Freight System v. Industrial Commission, 445 NE 2d.; 93 Ill.2d 280 507 (1983).

There is no dispute that Petitioner reinjured his neck and left arm while lifting a dolly off a truck on December 22, 2011. Petitioner complained immediately of severe neck pain and left arm pain when he reported to the emergency room at Rush University Medical Center. (Px. 4). According to the Respondent's expert, Dr. Harel Deutsch, "The work event represents an aggravation of the cervical degenerative disc disease." (Rx 1). Dr. Deutsch believed it was reasonable for him to undergo an anterior cervical diskectomy at C7-T1. *Id.*

Petitioner then began a several year course of medical care including three surgeries to his cervical spine. Petitioner's first cervical spine surgery was performed by Dr. Dixon on July 20, 2012 and involved an anterior cervical discectomy and fusion at C7-T1. Petitioner underwent a second surgery involving another cervical fusion on September 22, 2015. His third cervical surgery was performed by Dr. Dixon on November 22, 2015 and involved a posterior cervical laminectomy and foraminotomy at C4-5 and C6-7.

The Arbitrator takes note the only history contained in the medical records involves injuring his neck from lifting the dolly at work. While the Arbitrator notes Respondent's expert, Dr. Deutsch, opined that petitioner would be at maximum medical improvement three months subsequent to his initial work-related fusion surgery, the medical records clearly show that was not the case. Rather, Petitioner required ongoing surgeries, physical therapy, and pain management as result of continued cervical spine pain related complaints. The Arbitrator specifically finds that Petitioner's pain complaints throughout his years long course of medical care were consistent in the types of treatment he received were more likely than not related to the work accident that occurred while employed by Respondent.

Concerning the left elbow, the Arbitrator notes the Respondent's expert, Dr. Harel Deutsch, is a neurosurgeon, yet opined that the ulnar nerve entrapment and need for surgery would not be related to the work accident. Specifically, Dr. Deutsch opined that the Petitioner's initial complaints of pain are solely to the neck and shoulder, not elbow pain. That Deutsch further noted in this second IME report that cubital tunnel syndrome is not an acute injury and since there were no initial complaints after the injury of elbow pain, the need for elbow surgery would not be related to the work accident.

On August 26, 2013, Petitioner reported to Dr. Ryan Hennessey an orthopedic specialist for evaluation of his left elbow. Dr. Hennessy wrote in his report,"I told him we will do the ulnar nerve

transposition since it is a reasonable approach in my opinion and is related to his work accident from 2011. While Dr. Deutsch stated that he did not find a causal relationship, he bases his opinion on the fact there was no specific elbow pain despite two EMGs showing cubital tunnel syndrome after the accident in 2011. I respectfully disagree with him on the causal relationship." (Px. 17).

The Arbitrator finds Petitioner has proven by a preponderance of the evidence that his current conditions of ill-being to his cervical spine, including all three surgeries, as well as his left elbow and left elbow surgery related to his work injury on December 22, 2011. Specifically, the Arbitrator places more weight and credibility upon the treating doctors' opinions. The Arbitrator further notes that Dr. Deutsch believe that the initial cervical fusion was related to the work accident and never explained why the next two surgeries would not have also been related to the work accident. Additionally, the Arbitrator places more weight upon the orthopedic surgeon's opinion of Dr. Hennessy, rather than the opinion of a neurosurgeon concerning the causal relationship between the left elbow injury and the work accident.

Regarding the 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 services, the Arbitrator finds the following:

Having found Petitioner sustained work-related injuries to his neck and elbow on December 22, 2011, was an employee of Respondent having found his current conditions of ill being causally related, all medical care provided to Petitioner in order to resolve his cervical spine issues and left elbow issues have been reasonable and necessary. Respondent shall be responsible for the following medical bills: Blue Cross Blue Shield of Illinois – $65,176.18, Arthritis Treatment Center of the Low Country – $1,814.72, Low Country Spine and Sports – $1,023.00, Elmhurst Neuroscience Institute – $2,571.00, Achieve Manual Physical Therapy--$29,905.00, Connexus Pharmacy--$254.00, CVS--$2,372.68.

Regarding issue (K), what temporary total disability benefits are in dispute, the Arbitrator finds the following:

Having found Petitioner suffered injuries to his neck and elbow on December 22, 2011, the Arbitrator believes Petitioner should have been paid TTD benefits for the time he was authorized off work. Petitioner credibly testified he was off work from December 25, 2011 through December 16, 2016. Petitioner was paid TTD benefits through September 7, 2012. Petitioner was wrongly cut off TTD based upon the report of Dr. Deutsch. (Rx 1, 2). As the Arbitrator has noted, the treating doctors' opinions in this case carry more weight and credibility than the Respondent's paid expert.

The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from December 25, 2011 through December 15, 2016. This represents 261 and $1/7^{th}$ weeks of disability at a rate of $330.00 totaling $86,176.86. Respondent is due a credit of $26,258.56.

Regarding the issue (L), what is the nature and extent of the injury, the Arbitrator finds the following:

Section 8.1(b) of the Act states, "In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a)
(ii) the occupation of the injured employee
(iii) the age of the employee at the time of the injury
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records

No single enumerated factor shall be the sole determinant of disability."
For factor (i) no AMA rating was introduced into evidence, so no weight is given to this factor.

As for factor (ii), Petitioner was a phlebotomist for Respondent. According to Petitioner's testimony, based on the permanent work restrictions he received from his treating doctors, he is no longer able to perform that job. However, Petitioner has secured new employment with Walmart doing supervisory type work, but only performing work within his permanent 20-pound weight restriction. Petitioner has suffered a loss of trade based upon his work injuries and permanent work restrictions.

As for factor (iii), Petitioner suffered this work-injury at age 45. At the time of trial, he was 55 years old. This is an old enough age where it is unlikely Petitioner will continue to rehabilitate to a point where he could return to work in his former job as a phlebotomist.

As for factor (iv), while petitioner has secured employment with Walmart resulting in no wage loss differential, the job he is performing requires only supervisory type work. Some weight is given to this factor.

As for factor (v), this injury required Petitioner to undergo almost ten years of medical treatment including three cervical surgeries and one surgery to his left elbow. Petitioner testified that he continues to notice a sharp, dull, aching pain in his neck and left shoulder. Petitioner has permanent physical restrictions that substantially reduce his ability to lift and reduce his range of motion. With regards to the elbow, he continues to notice some tingling going down to his finger. (Tr. 32). He is unable to sleep on his right side and no longer drives a vehicle due to his prescribed medications. He continues to take Norco, Morphine and Tizanidine every day. (Tr. 34).

The Arbitrator finds Petitioner sustained a permanency loss of 40% man as a whole pursuant to Section 8(d)(2) of the Act and 20% loss of use of the left arm pursuant to Section 8(e) of the Act. This award amounts to 250.6 weeks of permanency at the rate of $330.00 totaling $82,698.00.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC031203
Case Name	SIMMONS, WILLIAM v. STATE OF ILLINOIS/ CHESTER MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0132
Number of Pages of Decision	17
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Kenton Owens

DATE FILED: 4/11/2022

/s/Marc Parker, Commissioner

Signature

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

William Simmons,

Petitioner,

vs. NO: 19 WC 31203

State of Illinois/Chester Mental Health Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 8, 2021, is hereby affirmed and adopted.

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

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

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

The bond requirement in Section 19(f)(2) of the Act is only applicable when the Commission has entered an award for the payment of money. Therefore, 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.

April 11, 2022

MP:yl
o 4/7/22
68

/s/ *Marc Parker*
Marc Parker

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC031203
Case Name	SIMMONS,WILLIAM v. ST OF IL/ CHESTER MENTAL
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Kenton Owens

DATE FILED: 8/8/2021

INTEREST RATE FOR THE WEEK OF AUGUST 3, 2021 0.05%

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

/s/ *Linda Cantrell, Arbitrator*

Signature

AUGUST 8, 2021

/s/ *Brendon O'Rourke*

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

WILLIAM SIMMONS
Employee/Petitioner

v.

STATE OF ILLINOIS/
CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **19** WC **031203**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 22, 2021**. After reviewing all 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, **9/30/19**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,591.22**; the average weekly wage was $**761.37**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit 1, as provided in §8(a) and §8.2 of the Act. Respondent shall have credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit. Respondent shall authorize and pay for the care and treatment recommended by Dr. Gornet, including but not limited to surgery.

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 Linda J. Cantrell

DATE: 08/08/21

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on June 22, 2021 pursuant to Section 19(b) of the Act. The parties stipulated that on September 30, 2019 Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. The issues in dispute are causal connection, medical bills, and prospective medical care with regard to Petitioner's lumbar spine only. The parties stipulated that no other body part or injuries are subject to this Section 19(b) hearing. All other issues have been stipulated.

TESTIMONY

Petitioner was 48 years old, married, with no dependent children at the time of accident. Petitioner is employed as a Security Therapy Aide at Chester Mental Health Center. Petitioner testified that on 9/30/19 he was assaulted and thrown to the floor while escorting a combative patient to a restraint room. He testified he landed on his knee and broke his kneecap in half and was taken to Chester Memorial Hospital. He testified he also injured his low back in the altercation. He was transferred to Missouri Baptist Hospital where his left knee was surgically repaired. Petitioner testified that the day after his knee surgery his low back pain intensified to the point it was unbearable. He admitted to low back treatment in 2011 due to a work-related accident that resulted in a lumbar fusion by Dr. Vaught. Petitioner then came under the care of Dr. Gornet in approximately 2012 or 2013 who ordered rhizotomies and a spinal cord stimulator. Petitioner testified he was able to return to work following that treatment. He stated the battery ran out in the stimulator and he no longer had to use it.

Petitioner testified that prior to his 9/30/19 incident, he took pain killers occasionally for low back pain after working 4 to 5 16-hour shifts. He did not miss work and was not working under any restrictions in the years prior to September 2019. He was hired by Respondent in August 2018. Following his 9/30/19 accident, Dr. Gornet performed a discogram and Petitioner experienced a severe pain down his hip into his buttocks. Dr. Gornet recommends a disc replacement.

Petitioner testified that while he was treating with Dr. Gornet he was also receiving treatment for his left knee. Dr. Bradley performed a partial knee replacement and he is still under Dr. Bradley's care. He currently has severe pain in his low back and buttocks. He stated it presently feels like a knife is being stuck in his back. He desires to undergo surgery as recommended by Dr. Gornet.

On cross-examination, Petitioner testified he worked out of the union hall for Illinois Excavators prior to becoming employed by Respondent. He started working out of the union hall in 2016. He testified he returned to Dr. Gornet on 1/20/18 and advised he was taking a job that was not as stressful and Dr. Gornet released him to full-duty work. Petitioner testified the job was in construction and his duties did not require heavy lifting.

Petitioner identified pain diagrams he completed in January 2018 and January 2020 for Dr. Gornet. The diagrams indicate low back pain. He identified a pain diagram dated 2015 which he completed that showed low back pain with almost the worst pain possible. He agreed he filed a workers' compensation claim against Bechtold Construction related to his 2011 injury for

which he received $350,000. He has had no other workers' compensation cases related to his back or left knee. Petitioner testified he was required to take a pre-employment physical before being hired by Respondent and he passed the test.

MEDICAL HISTORY

Immediately following the accident, Petitioner was transported by ambulance to Chester Memorial Hospital. It was noted Petitioner was brought to the ER by EMS after falling to the ground in an altercation with a patient. Petitioner's main complaint was his left knee, stating it twisted and his kneecap was not in the correct spot. He reported knee pain an 8 out of 10. X-rays showed an acute fracture of the patella. Petitioner was then transferred to Missouri Baptist Medical Center where a left distal pole patellectomy with patellar tendon advancement was performed. He was discharged the next day with a brace, given an order for home health care, and instructed to follow up within two to three weeks.

On 10/9/19, At Home Health Care came to Petitioner's home. Petitioner reported pain in his left knee and aching low back pain. Petitioner continued to report aching pain in both his left knee and low back to the nurses, rating his low back pain a 4 out of 10. Petitioner followed up with his knee surgeon Dr. Mudd on 10/16/19. Dr. Mudd noted Petitioner's knee was progressing well, ordered physical therapy twice weekly, recommended he continue Tylenol and oral anti-inflammatories, and kept Petitioner off work.

Petitioner completed a course of physical therapy for his left knee and returned to Dr. Mudd on 11/13/19. Dr. Mudd ordered more physical therapy for his left knee, ordered weight bearing as tolerated on his hinged knee brace, and placed him on light duty work restrictions with walking or standing occasionally, lifting 10 pounds maximum, no patient contact, and possible frequent breaks. Petitioner continued physical therapy and continued to see Dr. Mudd on a monthly basis. On 1/6/20, Dr. Mudd prescribed a T scope knee brace, ordered more physical therapy, and continued Petitioner on light duty restrictions.

On 1/9/20, Petitioner presented to Dr. Matthew Gornet for an initial evaluation of his spine. Dr. Gornet took Petitioner's history, noting he was an established patient of his who was presenting with low back pain central with pain between his shoulder blades. Petitioner reported his symptoms related to a work injury on 9/30/19 when he subdued a combative patient and was thrown down hard onto his left patella. Petitioner stated his knee pain was so severe he initially did not notice low back pain as much, but as he weaned off pain medications his back pain became more noticeable. Dr. Gornet noted he first saw Petitioner on 7/6/11 and the last time he saw him was on 1/20/18. At that time, he released Petitioner to work full duty with no restrictions and Petitioner had done well until this current event. Dr. Gornet noted there was a significant difference in his overall health from when he last saw Petitioner to his current visit. He noted he also had a stimulator placed by Dr. Boutwell years ago, which affected his ability to image him. Petitioner reported his current symptoms were constant and made worse with bending, lifting, and prolonged sitting or standing. X-rays of the lumbar spine revealed good position of his hardware and no evidence of new fracture. Dr. Gornet believed Petitioner aggravated his underlying low back condition and potentially had a new unspecified injury in his mid-back. Based on his knowledge of Petitioner before and after his work injury, Dr. Gornet

stated he believed his symptoms were caused by the 9/30/19 incident. He recommended MRIs of the thoracic and lumbar spine, prescribed physical therapy for his low and mid back, and prescribed work restrictions of a 10-pound weight limit, no repetitive bending or lifting, and alternating between sitting and standing as needed.

Petitioner presented to Apex Physical Therapy on 1/14/20 where he complained of low and mid back pain due to an injury at work on 9/30/19. Petitioner reported a history of a prior lumbar fusion and placement of a spinal cord stimulator in 2015. Upon examination, noted impairments were pain, limited lumbar range of motion, limited lower extremity flexibility, altered gait, and functional restrictions. He was recommended to complete physical therapy three times per week for six weeks. Petitioner completed physical therapy with no relief. At his reevaluation, Petitioner reported his worst pain felt like a knife stabbing him in the back, and he continued to have difficulty with bending. Petitioner also reported he was not able to receive an MRI of his lower back due to his stimulator. He stated the Medtronic representative reported he would have to have it removed and or replaced before the MRI could be completed.

On 2/27/20, Petitioner presented to Chester Memorial Hospital for an x-ray of his thoracic spine. Films revealed a neurostimulator positioned at the T9-10 level, mild anterior wedging of the T8-11 vertebral bodies, mild multilevel thoracic spondylosis at T8-9 and T9-10, and dextroconvex thoracic scoliosis.

On 3/19/20, Petitioner presented to Dr. Kaylea Boutwell at the St. Louis Spine & Orthopedic Surgery center for removal of his dead Meditronic stimulation system battery. Dr. Boutwell noted Petitioner did not need the therapeutic mechanism of his spinal cord stimulator for several years after the implant was placed. She noted the non-recharge of the battery resulted in a hard stop of the system. They attempted to recharge the battery with no success and determined re-implantation of a new battery with upgraded technology was the best course of action. Dr. Boutwell successfully performed the replacement and discharged Petitioner. Petitioner returned to Dr. Boutwell two weeks later and she noted Petitioner had continued severe back pain which increased with activity, despite using the stimulator again. Dr. Boutwell removed the dressing from his wound site and instructed him to avoid submersion in water for two weeks following his stimulator replacement surgery.

Petitioner had thoracic and lumbar MRI scans performed on 3/31/20. On 4/9/20, Dr. Gornet noted the lumbar MRI showed some subtle changes and a potential annular tear at L4-5 and possible protrusions at L2-3 and L3-4. On the thoracic MRI, Dr. Gornet appreciated a disc protrusion at C5-6, which he noted could easily cause pain between his shoulder blades. He also noted facet changes at the L4-5 level. Dr. Gornet recommended starting with medial branch blocks and facet rhizotomies at L3-4 and L4-5. If Petitioner continued to have pain between his shoulder blades, he recommended an injection at C5-6 centrally. Dr. Gornet referred Petitioner to Dr. Helen Blake for the injections and believed Petitioner's current symptoms and requirement for treatment were causally connected to his accident of 9/30/19.

Throughout his treatment with Drs. Gornet and Blake, Petitioner continued physical therapy for his left knee and followed up with Dr. Mudd. Due to his continued left knee symptoms, Petitioner received an MRI of his left knee that showed some tendinopathy of the

patellar tendon and there did not appear to be a contiguous attachment of the patellar tendon to the distal pole of the patella. Dr. Mudd noted Petitioner improved considerably, but still had some weakness and clunking in his knee. Dr. Mudd ordered continued physical therapy and recommended he follow up in four months. He placed him on medium light work with no direct contact with patients.

On 6/2/20, Petitioner had a phone appointment with P.A. Allyson Joggerst with Dr. Gornet's office. Petitioner reported continued central low back pain and pain between his shoulder blades. Ms. Joggerst stated they were first treating his low back with medial branch blocks and facet rhizotomies and were holding off on treating his disc protrusion at C5-6. She noted it had been difficult to schedule Petitioner for blocks and rhizotomies due to the pandemic, but they were trying to move it forward.

On 6/16/20, Petitioner presented to Dr. Matthew Bradley for further evaluation of his left knee. Dr. Bradley took a consistent history of accident and noted that at the time of his injury Petitioner also injured his back and was treating with Dr. Gornet. Dr. Bradley believed Petitioner had pain secondary to posttraumatic arthritis of his patellofemoral joint in combination with some chronic tendinopathy of his patellar tendon. He recommended an intraarticular corticosteroid injection, which was performed at the visit. He ordered a CT scan and ordered Petitioner to follow up in three to four weeks. Dr. Bradley opined Petitioner's pain and symptomatology of anterior knee pain was a direct sequela of his fracture and subsequent treatment related to the trauma he suffered on 9/30/19.

On 6/25/20, Dr. Helen Blake performed bilateral median nerve branch blocks of the L3-4 and L4-5 facet joint areas. On 7/2/20, Petitioner reported immediate relief with the injections, but his pain had fully returned. On 7/7/20, Dr. Blake performed bilateral radiofrequency ablations of the L3-4 and L4-5 facet nerves. Petitioner followed up with Dr. Blake two weeks later and reported his pain had improved somewhat since the procedure, with continued pain radiating across his back into his legs. Dr. Blake stated it would be unlikely that the pain radiating into his feet would be managed with the radiofrequency ablations.

Petitioner returned to Dr. Gornet on 8/3/20 who noted Petitioner's pain was coming from the degeneration at T11-12, which he suspected Petitioner aggravated. Dr. Gornet recommended an epidural steroid injection, kept him off work, and recommended a home exercise program.

On 8/6/20, Dr. Bradley noted the CT scan of Petitioner's left knee showed a significant amount of scalloping to the articular surface of the patella with fragments noted superiorly and interiorly. Dr. Bradley recommended a left patellofemoral arthroplasty which was performed on 8/14/20. Following surgery, Dr. Bradley noted Petitioner was doing very well, ordered he remain off work, and ordered physical therapy.

On 8/20/20, Dr. Blake performed an L1-2 epidural injection to treat the T11-12 level. A few weeks later, Petitioner called Dr. Gornet's office with increased low back pain to his left lower extremity for the last two weeks and reported his stimulator was not helping. Dr. Gornet prescribed Prednisone and Famotidine for GI prophylaxis.

A few weeks later, Petitioner presented to the Chester Clinic for back pain and requested an increase in his Norco dosage. Dr. James Krieg recommended he try Cymbalta and to follow up if there was no improvement. Petitioner returned to Dr. Gornet on 10/5/20 who recommended Petitioner return to Dr. Boutwell to evaluate his stimulator. He also recommended a CT discogram at the L3-4 and L4-5 levels to determine whether he had a structural injury and whether that may be the source of his pain.

On 10/21/20, Petitioner presented to Dr. Boutwell at the recommendation of Dr. Gornet. Dr. Boutwell noted Petitioner's injury on 9/30/19 and that Petitioner reported his back was doing "perfectly great" until the altercation. Dr. Boutwell noted the possibility of altering Petitioner's stimulator programming but did not personally see anything relating to the stimulator that would be causing his pain. She noted the wear of the generator on examination was not problematic and Petitioner did not appear to have a primary discomfort associated with the device. Reprogramming was done of the stimulator and Petitioner reported he was feeling a difference.

On 11/3/20, the CT discogram was performed. X-ray interpretations revealed a normal nucleogram at L3-4 with a left-sided tear and a disrupted nucleogram at L4-5 with tears in multiple directions. Stimulation revealed a non-provocative disc at L3-4 and a provocative disc at L4-5 with mild degeneration of the nucleogram and bilateral annular tears. Petitioner continued to see Dr. Bradley for his left knee and continued to participate in physical therapy. Dr. Bradley noted Petitioner developed some slight patellar tendonitis with prepatellar bursitis and continued Petitioner on physical therapy, a home exercise program, and light duty.

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Respondent had Petitioner examined by Dr. Robert Bernardi on 11/27/20 pursuant to Section 12 of the Act. Dr. Bernardi took Petitioner's history, noting he injured his low back at work on 9/30/19 while employed as a security therapy aide. He noted Petitioner was off work until January 2020 and six months later had exhausted his allotted light duty and had been off since then. He noted Petitioner had a prior history of low back issues dating back to 2011, when he had a lumbar fusion, and 2013, when he had a stimulator placed to address residual aching in his feet and legs. Petitioner reported the day after his accident he told his wife his back was bothering him and over the next month it did not improve. Petitioner stated in November 2019 he called to make an appointment with Dr. Gornet but he could not be seen until January 2020. He noted there were problems obtaining imaging studies due to his dorsal column stimulator. Dr. Bernardi noted Petitioner had midline lower lumbar pain and intermittent right buttock discomfort, which Petitioner stated was reproduced during his discogram. Petitioner reported bilateral leg pain and weakness in both lower extremities and at the thoracolumbar junction. Dr. Bernardi reviewed Petitioner's medical records, including a Notice of Injury and Staff Injury Summary, records from Medstar Ambulance, Missouri Baptist Medical Center, At Home Health Care, Dr. Mudd, Dr. Gornet, Imaging Partners of Missouri, Dr. Bradley, and Dr. Blake, from the date of accident through 10/5/20, and the lumbar MRI dated 3/31/20.

Upon physical examination, Dr. Bernardi noted Petitioner's lumbar extension was essentially nonexistent. Dr. Bernardi did not believe the films dated 3/31/20 showed any findings that could be attributed to the assault, and believed they were minor degenerative changes. He did not agree with Dr. Gornet's recommendation of a CT discogram. Dr. Bernardi believed the diagnostic testing and treatment Petitioner received for his lumbar complaints, besides the

discogram and stimulator battery pack replacement, were reasonable and necessary. He found Petitioner to be credible. He noted that Petitioner stated that after his previous lumbar fusion he vowed he would never have another, but felt at this point he might be ready. Dr. Bernardi believed Petitioner was at MMI and he could return to work full duty with no restrictions.

On 12/7/20, Petitioner returned to Dr. Gornet who noted the CT discogram revealed a 0 to 1 level of pain at L3-4 and a 7 to 8 level of pain at L4-5, which was typical of concordant back and buttock pain. Dr. Gornet believed the majority of Petitioner's structural back pain was coming from L4-5. Petitioner's options were to live with his condition or undergo further treatment in the form of a lumbar disc replacement at L4-5. Dr. Gornet noted Petitioner remained temporarily totally disabled and kept him off work. Petitioner completed pre-operative labs at the Chester Clinic as well as the St. Louis Cardiovascular Institute for the future surgery.

Petitioner continued to treat with Dr. Bradley for his knee and participate in physical therapy. Petitioner continued to have an inability to fully extend his knee and had continued weakness in his quadriceps. Dr. Bradley performed a cortisone injection and noted he may need to explore operative treatment options, including a quadriceps shortening and reattachment tie procedure in order to gain full extension.

On 3/11/21, Petitioner returned to Dr. Gornet who noted Petitioner continued to be seen for structural pain, which was more central to both sides, but particularly the right buttock and hip, as well as mid-back pain. Dr. Gornet noted his recommendation was a single level lumbar disc replacement at L4-5. Dr. Gornet stated he had never seen Petitioner in so much pain before and he continued to believe his symptoms and requirement for treatment were related to his 9/30/19 accident. Petitioner remained temporarily totally disabled.

Petitioner presented to Dr. Jodi Buskohl at Southern Illinois Chiropractic on 4/12/21 for continued back pain. Dr. Buskohl noted Petitioner presented with mid back pain which had been worsening in the past few weeks. Her examination revealed spasm and tenderness of the rhomboid on the right and bilateral longissimus muscles. She noted the thoracic segments from T4-T10 were restricted due to spasm and noted a prominent subluxed rib-head on the right at T6-7. Dr. Buskohl performed an adjustment and informed Petitioner he could return as needed.

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On 4/19/21, Petitioner returned to Dr. Boutwell who noted Petitioner was pending lumbar disc replacement with Dr. Gornet. Upon examination, Petitioner reported worsened mid back discomfort with his pain reaching an 8 out of 10. Petitioner stated he was taking Norco for his pain. She found his range of motion to be restricted in all planes in his lower back and had a pulling sensation in his upper back. Dr. Boutwell recommended trigger point injections along the thoracic paraspinal muscles, which were performed at the visit. Petitioner tolerated the procedure well and was recommended to follow up as needed.

Petitioner continued to seek treatment for his left knee with Dr. Bradley with continued symptoms and inability to fully extend his knee. Dr. Bradley recommended a left knee replacement with shortening of the quadriceps tendon versus advancement of the tibial tubercle to help Petitioner achieve full extension. Surgery was performed on 4/28/21 in the form of an arthroscopic partial medial meniscectomy, chondroplasty, open total synovectomy, revision of

the left patellofemoral arthroplasty, and femoral block. Petitioner did well following surgery and started physical therapy. Dr. Bradley kept Petitioner off work until further notice.

Respondent sent Dr. Bernardi additional records to review, for which he authored an addendum to his Section 12 report on 5/15/21. Dr. Bernardi reviewed the CT discogram from 11/3/20, Dr. Gornet's 12/7/20 note, a lumbar MRI from 2015, and Dr. Gornet's deposition testimony. His opinions remained unchanged.

Dr. Gornet testified by way of evidence deposition on 3/1/21. Dr. Gornet is a board-certified orthopedic surgeon whose practice is devoted to spine surgery. He testified he sees about 100 to 120 patients per week, performs five to ten surgeries per week depending on complexity, and is a contributing editor to three different spine journals. Dr. Gornet also participates in numerous FDA clinical trials, which focus on neck and back pain, and lectures on the topic throughout the United States and around the world. Dr. Gornet testified Petitioner had been a past patient of his dating back to August 2012. He stated Petitioner's previous injury happened on 7/6/11 which led him to have a posterior lumbar interbody fusion by Dr. Kevin Vaught at L5-S1. Dr. Gornet stated in 2013 Petitioner had a dorsal column stimulator placed by Dr. Boutwell. He testified that Petitioner returned to his job following the implant of the stimulator. The first time he saw Petitioner following his 9/30/19 accident was on 1/9/20 at which time he reported low back pain and central pain between his shoulder blades. Dr. Gornet felt Petitioner's symptoms were related to the 9/30/19 accident. Dr. Gornet stated initially, Petitioner's knee pain was so severe he did not sense the issue of his back pain. As he weaned off his narcotics his back pain became more noticeable. Dr. Gornet stated he had followed Petitioner since 2011 and at his last visit on 1/20/18 he released Petitioner back to work full duty with no restrictions. He stated Petitioner had done well until the 9/30/19 incident. After conducting a physical examination, taking his history, and performing x-rays of the spine, Dr. Gornet testified his working diagnosis was that Petitioner aggravated his underlying condition in his low back and potentially had a new injury in both his low back and mid-back. He placed Petitioner on light duty at that time and recommended MRIs. Dr. Gornet opined the new MRIs showed some changes consistent with a potential tear in the disc at L4-5, a potential foraminal protrusion at L2-3 and L3-4, a disc protrusion at C5-6, some disc degeneration at T11-12 that may have been aggravated, and some facet changes at the L4-5 level. He stated at that time, his working diagnosis was a potential disc injury at L4-5, an aggravation of his underlying condition, and a disc injury in his cervical spine at C5-6. Dr. Gornet then recommended medial branch blocks and facet rhizotomies and Petitioner responded to the injections to some extent. Dr. Gornet testified at his visit of 8/3/20 his recommendation was continuing home exercises potentially getting Petitioner back to work.

Dr. Gornet testified that on 10/5/20 Petitioner was struggling more and was continuing to have mid back pain and pain in general that was significantly affecting his quality of life. Dr. Gornet stated this was a major change for Petitioner since he began treating him in 2011. Dr. Gornet his stimulator be checked and a CT discogram at L3-4 and L4-5. Dr. Gornet stated Petitioner's stimulator was found not to be functioning well as the battery stopped. After the stimulator was repaired and Petitioner resumed use, it did not help his structural back pain, as stimulators are designed to help with chronic radiculopathy.

Dr. Gornet testified he recommended a discogram because at that point Petitioner was struggling and failed conservative measures. Discograms are used to look for structural disc pathology that is associated with pain. He explained that people can have tears in their discs and have no significant back pain, but when the disc is injured in a certain subset of patients, nerve fibers grow into the disc which causes it to become painful with any type of loading. He stated the discogram is both an objective and subjective test, as the patient's pain response is subjective, but the patient is blinded as to what disc is being provoked, so it is also objective. He stated the anatomic pathology seen on the discogram is objective. Dr. Gornet testified the results of Petitioner's discogram clearly showed a tear in the disc at L4-5, which was new, and that further supported the injury and correlated with the MRI scan. At his last visit with Petitioner on 12/7/20, Dr. Gornet stated Petitioner's options were to live with the pain or undergo a disc replacement at L4-5. Dr. Gornet stated it is his recommendation to move forward with the disc replacement at L4-5.

Dr. Gornet opined Petitioner's injury was directly caused by his accident on 9/30/19. He based his opinion on knowing Petitioner before and after the injury and noting a dramatic structural change in his overall medical condition. He was working full duty and is now essentially limited in pain. MRI scans also show structural changes at L4-5, which was not present on the previous MRIs. Petitioner's CT discogram correlates with a structural change in his disc and disc mechanism at L4-5, which was not present on the discogram dated 10/27/11 performed by Dr. Vaught. This new finding correlates with Petitioner's pain. Petitioner was doing well, working full duty, without the use of the stimulator prior to 9/30/19.

Dr. Gornet believed Petitioner's prognosis following surgery at L4-5 is fairly good and there is a possibility Petitioner could return to full duty work. Dr. Gornet testified he reviewed Dr. Bernardi's Section 12 report and the interpretation of the radiologist from Petitioner's MRIs of mild disc pathology at L3-4 and L4-5, with which he agreed. Dr. Gornet stated he did not believe the discs at L3-4 and L4-5 were "entirely normal."

On cross-examination, Dr. Gornet testified he had previously reviewed MRIs of Petitioner's lumbar spine from 2013, 2014 and 2015, as well as a CT scan in 2014. Dr. Gornet stated he sometimes sees patients every two years for long-term data collection but did not believe Petitioner was involved in a long-range study for his previous injury. He reiterated that when he saw Petitioner in January 2020, he was in substantially more back pain than anything he had in the past. Dr. Gornet also testified he reviewed Petitioner's MRI in 2015 and did not appreciate any major changes at the L4-5 level.

Dr. Robert Bernardi testified by way of evidence deposition on 5/28/21. Dr. Bernardi testified he specializes in neurosurgery, confined to spinal problems. He stated he saw Petitioner in November 2020 and noted his accident at work on 9/30/19 where he fell and landed on his left knee. He stated Petitioner reported the very next day he noticed his back was sore and the pain in his knee overpowered his back symptoms at first. Dr. Bernardi reviewed Petitioner's MRIs from 3/31/20 and noted arthritis in the facet joints at L4-5 which he believed predated the work accident. Dr. Bernardi stated Petitioner had no findings on his imaging studies that could be related to the accident and that one could "conjecture or hypothesize" that he aggravated a pre-existing problem in his back. Dr. Bernardi testified he did not believe Petitioner needed lumbar

disc surgery due to the facet changes in his spine at L4-5. Dr. Bernardi also testified Petitioner's post-discogram CT was interpreted as showing tears at L3-4 and L4-5. He believed all of Petitioner's treatment had been reasonable and necessary, except for the replacement of the dorsal column stimulator if it was solely replaced to take the MRI scan and the recommended lumbar disc surgery.

On cross-examination, Dr. Bernardi stated he sees about 30 patients per week and completes about two independent medical examinations per week. He agreed Petitioner's low back pain was bad enough following the accident that he contacted Dr. Gornet in November 2019. He testified Petitioner was pleasant, cooperative, and there was no symptom magnification, Waddell's Signs, or malingering at the time of his exam. Dr. Bernardi reviewed records pertaining to Petitioner's 2011 lumbar fusion and his 2013 dorsal column stimulator implantation. He did not review any of the CAT scans from 2012 to 2014. Dr. Bernardi testified Petitioner was not taking any medication for residual back or leg pain prior to the accident and was not using the dorsal column stimulator. He was not provided with any medical records pre-dating the work accident, except the 2015 MRI. He stated he evaluated Petitioner one year and two months after his accident. Dr. Bernardi testified that the radiologist interpreting Petitioner's MRI on 3/31/19 did not use the term arthritis anywhere in the report, but used the term arthropathy at L4-5. Dr. Bernardi agreed that even trivial trauma can aggravate underlying stenosis and arthritis. He testified that in reviewing the 2015 and 2020 MRIs, he noted changes in Petitioner's degenerative facet disease at L4-5 and associated formainal stenosis, as well as some evolution of the facet process at L4-5. Dr. Bernardi testified that there was a correlation between Petitioner's symptoms at L4-5 and the results of the discogram. He agreed the mechanism of injury Petitioner reported could cause or aggravate an underlying condition of the lumbar spine.

CONCLUSIONS OF LAW

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

The law holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003). [Emphasis added]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 309 Ill. App. 3d 1037, 723 N.E.2d 846 (2000). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm'n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999), citing *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967), 37 Ill. 2d 123; see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

The parties stipulated that the sole dispute with respect to causation is whether Petitioner's condition of ill-being in his back is causally related to his accidental work injury. Based upon the objective and circumstantial evidence, the Arbitrator finds that Petitioner's

condition in his back, specifically the L4-5 level, is causally related to his work accident of 9/30/19.

Petitioner was working full duty with no restrictions prior to his work accident. Petitioner passed a pre-employment physical prior to being hired by Respondent in August 2018. Petitioner testified credibly that he experienced pain in his back the day after the accident, but his left knee injury was significant and overpowered his back symptoms. Petitioner's low back symptoms were documented as early as nine days after the accident by his home health care providers. Petitioner's objective studies show pathology at the L4-5 level, including an annular tear. Petitioner's CT discogram revealed a left-sided tear at L3-4 and tears in multiple directions at L4-5, with stimulation revealing L4-5 to be a provocative disc, as his pain levels reached a 7 to 8 out of 10. These findings were further buttressed by Dr. Gornet's history of treating Petitioner, as he had been his patient for nine years. Dr. Gornet opined it was clear Petitioner had a dramatic change following the 9/30/19 accident, as he went from full duty working to being very limited with pain. Dr. Gornet opined his treatment of Petitioner for over nine years combined with the objective results of the MRI, the objective and subjective results of the CT discogram, and his treatment of like or similar individuals led him to believe the changes at his L4-5 disc were associated with the work injury.

Dr. Bernardi acknowledged Petitioner suffered an increase in pain following the accident, but denied Petitioner suffered any injury or aggravation at L4-5. The Arbitrator does not find this opinion credible in light of the aforementioned medical evidence. Dr. Bernardi provided no credible explanation as to why Petitioner was working full duty with no restrictions prior to the accident and had a sudden extreme increase in pain following the work injury. He only stated that the additional diagnostic testing that revealed evidence of injury at L4-5 was unreliable or unnecessary. The Arbitrator notes Dr. Bernardi reviewed Petitioner for one examination and only reviewed records of one MRI prior to the date of accident, compared to Dr. Gornet's nine-year history with Petitioner and his continuous treatment of Petitioner following the 2019 work accident.

Based upon the objective diagnostic studies and the circumstantial evidence, the Arbitrator finds the causation opinion of Dr. Gornet persuasive and well-supported by the evidence and finds that Petitioner has met his burden of proof on the issue of causal connection.

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

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

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 383, 902 N.E.2d 1269, 1273 (2009). Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to

diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Based upon the above findings as to causal connection and the objective medical evidence showing pathology accountable for his symptoms, the Arbitrator finds Petitioner is entitled to the reasonable and necessary medical care administered and recommended. Dr. Bernardi disputes use of a lumbar disc replacement at L4-5 to treat Petitioner's symptoms as he believes Petitioner only has arthritis and facet changes at that level. Dr. Gornet, however, explained that objective and subjective medical evidence clearly shows pathology and symptoms in the form of a symptomatic annular tear. Based upon the objective results from the diagnostic tests performed, the Arbitrator finds Dr. Gornet's opinion persuasive. The Arbitrator also adopts Dr. Gornet's belief regarding the reasonableness and necessity of the diagnostic tests performed, as these were reasonably prompted by Petitioner's report of increasing symptoms, and further served to establish the source of Petitioner's condition of ill-being.

Respondent shall pay the reasonable and necessary medical expenses outlined in Petitioner's group exhibit 1 pursuant to the medical fee schedule or a PPO agreement (whichever is less) as provided in §8(a) and §8.2 of the Act.

Respondent further shall authorize and pay for the care and treatment recommended by Dr. Gornet, including but not limited to surgery.

This award shall in no instance be a bar to further hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

Arbitrator Linda J. Cantrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC022344
Case Name	PIERCE, ROXIE R v. WALGREENS FAMILY OF COMPANIES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0133
Number of Pages of Decision	20
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Joshua Humbrecht
Respondent Attorney	Michael Karr

DATE FILED: 4/11/2022

/s/Marc Parker, Commissioner

Signature

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

Roxie R. Pierce,

Petitioner,

vs. NO: 17 WC 22344

Walgreens Family of Companies,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 2, 2021, is hereby affirmed and adopted.

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

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

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

The bond requirement in Section 19(f)(2) of the Act is only applicable when the Commission has entered an award for the payment of money. Therefore, 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.

April 11, 2022

MP:yl

o 4/7/22
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/s/ *Marc Parker*
Marc Parker

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC022344
Case Name	PIERCE, ROXIE R v. WALGREENS FAMILY OF COMPANIES
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	17
Decision Issued By	Jeanne AuBuchon, Arbitrator

Petitioner Attorney	Joshua Humbrecht
Respondent Attorney	Michael Karr

DATE FILED: 9/2/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 31, 2021 0.05%

/s/ Jeanne AuBuchon, Arbitrator

Signature

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)

Roxie R. Pierce
Employee/Petitioner

v.

Walgreens Family of Companies
Employer/Respondent

Case # 17 WC 22344

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 Jeanne L. AuBuchon, Arbitrator of the Commission, in the city of Collinsville, on May 10, 2021. After reviewing all 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 4, 2015, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $27,274; the average weekly wage was $524.50.

On the date of accident, Petitioner was 32 years of age, with 4 dependent children.

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

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

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

ORDER

In light of the Arbitrator's findings on the issue of causation and prospective medical care, Respondent shall authorize and pay for the treatment recommended by Dr. Thompson, specifically further diagnostic testing, injections, therapy and potential surgery.

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.

Jeanne L. AuBuchon

Signature of Arbitrator

SEPTEMBER 2, 2021

PROCEDURAL HISTORY

This matter proceeded to trial on May 10, 2021, pursuant to Sections 19(b) and 8(a) of the Illinois Workers' Compensation Act (hereinafter "the Act"). The issues in dispute are: 1) the causal connection between the accident and the Petitioner's alleged thoracic outlet syndrome (TOS) and 2) entitlement to prospective medical care. The parties stipulated that an injury to the Petitioner's left shoulder is not disputed.

FINDINGS OF FACT

At the time of the accident, the Petitioner was 32 years old and employed by the Respondent in the receiving department, where she would unload product from semi trailers, break it down and reload the items for further distribution. (T. 10) Her job involved using a forklift and fork truck, unwrapping shrink wrap, lifting, stacking and scanning. (T. 10-11) On March 4, 2015, the Petitioner had carpooled to work with her husband, who also worked for the Respondent, when she fell on ice while exiting the couple's pickup truck. (T. 13) The Petitioner, who is 5'2" tall, stated that her left foot was on the truck running board when she stepped on the snow-covered ice with her right foot, landing on her left side. (Id.) As she went into the building to clock in, the Petitioner began feeling pain in her left leg and later felt pain in her neck, shoulder and collar bone area. (T. 14-17) Her injury report to the Respondent was consistent with this testimony. (PX11) However, the human resources specialist who took the report questioned the validity of the claim, stating that there was video of the Petitioner falling against her car and appearing to never hit the ground. (Id.) This video was not introduced into evidence. The human resources specialist also reported that the Petitioner drove herself to work but exited the vehicle on the passenger side. (Id.) The Petitioner filled out an "Accident Investigation and Symptom Form" on March 23, 2015, in which she complained of sharp pains in her shoulder and collarbone. (Id.)

The Petitioner testified that she had no prior problems with her left shoulder, neck or clavicle/collar bone area. (T. 18) She had bilateral carpal tunnel releases in 2012 and bilateral elbow repair in 2013 and 2014 performed by Dr. Jeffrey McIntosh, an orthopedic surgeon at Crossroads Community Hospital. (T. 19-20, PX12) The Petitioner said she had no more problems with her elbows or hands after that and was able to work full duty without any issues. (T. 21-22)

On the date of her fall, the Petitioner was treated at Work Injury Solutions, an in-house therapy/athletic training provider. (T. 16) She had six therapy sessions March 6-20, 2015. (PX11) She testified that the pain in her left leg resolved in a month or two. (T. 18-19) However, the treatment she received at Work Injury Solutions did not improve her shoulder and neck symptoms, and she was referred back to Dr. McIntosh. (T. 23) She saw Dr. McIntosh on April 29, 2015, complaining of pain in her left shoulder, clavicular region and neck. (PX12, PX4) She characterized the pain as burning and aching. (Id.) Dr. McIntosh prescribed oral steroids, anti-inflammatory medication and physical therapy focusing on rotator cuff stretching and strengthening. (Id.) While Dr. McIntosh focused treatment on the Petitioner's shoulder, she continued to complain of pain in her neck and/or clavicular area. (PX4) The Petitioner underwent physical therapy at NovaCare Rehabilitation for five visits May 7-18, 2015. (PX8) During the therapy, she complained of pain in her neck and clavicular area. (Id.)

On May 20, 2016 – after a lapse in treatment due to pregnancy and childbirth – Dr. McIntosh performed left shoulder arthroscopy with debridement of partial rotator cuff tear and subacromial arthroscopy with bursectomy and acromioplasty. (PX4, PX10) Afterwards, the Petitioner continued to complain of pain in her neck and clavicular area. (PX4) She underwent physical therapy at NovaCare Rehabilitation for eleven visits from July 1, 2016, through August 11, 2016, for her shoulder and five visits from September 22, 2016, through October 3, 2016, for

her neck. (PX8) Therapy notes showed complaints of pain to her left upper-thoracic/neck and collar-bone/clavical areas during the course of therapy. (PX8) The Petitioner testified that by October 2016, her left shoulder was fine, and she was not experiencing numbness or tingling in her left arm, hand or fingers. (T. 43) But the burning in her neck and collar bone and sternum areas did not resolve and continued when she returned to light duty work, which consisted of cutting open boxes, taking out products, putting sensor tags on them, putting them back in the boxes and taping the boxes. (T. 26-27)

Dr. McIntosh ordered an MRI that was performed on December 19, 2016, and showed a normal cervical spine, although the MRI was of poor quality. (PX4, PX6) Dr. McIntosh referred the Petitioner to Dr. Ahmed Salem Mohamed (Dr. Salem), an orthopedic spinal surgeon at Egyptian Spine Clinic. (PX4) The Petitioner saw Dr. Salem on February 20, 2017, at which time she reported posterior cervical spine pain with radiation over her shoulder blade and both arms. (PX5) She described the pain as aching, cramping, shooting and stabbing that was worse during the day and exacerbated by physical activities and sustained neck postures. (Id.) Associated symptoms included arm pain, numbness, paresthesias and tingling. (Id.) Dr. Salem ordered another MRI that was performed on April 19, 2017, and showed reversal of cervical lordosis suggesting muscle spasm but was otherwise normal. (PX5, PX7. PX10) On April 21, 2017, Dr. Salem prescribed physical therapy and stated that the Petitioner may benefit from a consultation with a pain management specialist. (Id.) The Petitioner underwent physical therapy at NovaCare Rehabilitation for three visits from April 26, 2017, through May 1, 2017. (PX8) The Petitioner testified that the therapy she underwent pursuant Drs. McIntosh and Salem's orders aggravated her symptoms, specifically her neck and collar bone pain that then progressed into her arm. (T. 29)

On May 2, 2017, the Petitioner underwent a Section 12 examination by Dr. David Raskas, an orthopedic surgeon at Orthopedic Sports Medicine & Spine Care Institute. (RX2) He reviewed the cervical spine X-rays and the MRI from April 19, 2017. (Id.) The Petitioner reported pain in her neck and left anterior collarbone. (Id.) Dr. Raskas stated there was no real scapular pain "right now." (Id.) He said the Petitioner had a numbness sensation going down the radial border of her arm and had some burning, aching and stabbing sensations around the medial elbow area. (Id.) She also reported she was starting to get the same numbness in her right hand and was starting to experience symptoms somewhat in her upper extremity. (Id.) In describing the accident in his report, Dr. Raskas stated that the Petitioner did not fall all the way to the ground but fell against the car. (Id.) He diagnosed the Petitioner with cervical pain, TOS and pain in her scapula. (Id.)

Dr. Raskas opined that the Petitioner's symptoms at that time were not related to the work injury. (Id.) He acknowledged that she may have some component of TOS but did not believe it was related to the work injury – either by direct cause or aggravation – and stated the mechanism of injury was not consistent with one that would cause TOS. (Id.) He said the nature and extent of the report injury appeared to be that the Petitioner developed a tendinitis subacromial impingement type syndrome that appeared to have been adequately treated by Dr. McIntosh. (Id.) He ruled out a cervical condition and stated that the Petitioner's condition was developmental, was not related to any repetitive use or trauma and was idiopathic in its cause, "if it exists at all." (Id.)

Dr. Raskas believed Dr. McIntosh's treatment and Dr. Salem's evaluation were reasonable but did not believe any further physical therapy or medications would have been necessary. (Id.) he believed the Petitioner did not need any physical limitations or work restrictions as a result of the work injury. (Id.) He believed the Petitioner was at maximum medical treatment when treatment ceased regarding her shoulder. (Id.) Dr. Raskas did not testify.

In her testimony, the Petitioner disagreed with Dr. Raskas' description of how the accident occurred. (T. 32) She said that although it was possible that some part of her body hit the truck on the way down, she absolutely fell to the pavement. (Id.)

In October 2017, the Petitioner reported another work injury in which she was working on a clamp truck unloading product and her hand locked up. (T. 33) She went to the emergency department at Crossroads Community Hospital on October 21, 2017, stating that while at work on the previous day, her hands began hurting with a tingling sensation and shooting pain radiating up to her shoulders. (PX10) She testified that she had not experienced these symptoms from March 2015 until that time. (Id.) The hospital X-rayed the Petitioner's hands and wrists, and the X-rays were unremarkable. (T. 33) The Petitioner was diagnosed with bilateral carpal tunnel syndrome and was instructed to take Tylenol, wear a splint and return to the emergency department or see a private physician if her symptoms worsened. (Id.)

The Petitioner underwent a Section 12 examination on June 5, 2018, by Dr. R. Evan Crandell, a plastic surgeon at Aesthetic & Reconstructive Surgery Associates. (PX14, RX3) Dr. Crandell examined the Petitioner and recommended a nerve conduction study to determine if the Petitioner had carpal tunnel syndrome, ulnar neuropathy or some other nerve compression syndrome. (Id.) He also stated it was possible the Petitioner could have a cervical radiculopathy. (Id.) He could not place the Petitioner at maximum medical improvement until there was a diagnosis and treatment plan, if needed, and allowed the Petitioner to work without restrictions. (Id.) Nerve conduction studies were conducted on February 19, 2020, and were negative. (PX9)

On October 4, 2018, the Petitioner underwent an independent medical examination at the request of her attorney with Dr. Robert Thompson, a vascular surgeon who is director of the Center for Thoracic Outlet Syndrome at Washington University School of Medicine. (PX3) After

reviewing the Petitioner's medical history and examining her, he diagnosed her with left neurogenic TOS with dynamic brachial plexus nerve compression at the supraclavicular scalene triangle and the subcoracoid pectoralis minor tendon. (Id.) He explained that the Petitioner's history, description of symptoms, previous testing results and physical examination findings were all entirely consistent with, and characteristic of, the stated diagnosis. (Id.)

Dr. Thompson reported that an upper limb tension test (ULTT) was strongly positive during provocative maneuvers. (Id.) A three-minute elevated arm stress test (EAST) resulted in the Petitioner developing left upper extremity symptoms within 10-20 seconds and being unable to continue beyond 60 seconds. (Id.) He characterized this as a markedly positive EAST. (Id.) A Disabilities of the Arm, Shoulder and Hand (DASH) survey the Petitioner completed indicated a score of 50 that Dr. Thompson characterized as markedly elevated, in that DASH scores above 30 are generally considered to reflect substantial functional disability. Dr. Thompson also reported that the Petitioner met 10 of the 14 clinical diagnostic criteria in 5 of 5 categories, making it a strong clinical diagnosis. (Id.) He found no evidence to indicate arterial or venous forms of TOS and no findings to suggest the Petitioner's symptoms were attributable to a cervical spine source, peripheral nerve compression syndrome or another condition. (Id.)

Dr. Thompson opined that the left shoulder injury from the work accident was the principal and prevailing cause of the Petitioner developing neurogenic TOS and the resulting symptoms. (Id.) He stated that the shoulder injury did not explain the full breadth of the Petitioner's symptoms, and the surgery did not alter the symptoms that she continued to experience. (Id.) He explained that the Petitioner' work activity included repetitive upper extremity activity, frequent lifting and long periods of time driving a motor vehicle – all activities that may have aggravated symptoms and contributed to the progression of neurogenic TOS, particularly since the time of her

injury. (Id.) Dr. Thompson warned that the Petitioner was at significant risk of further secondary injury and aggravation of neurogenic TOS as well as any disability that may subsequently occur. (Id.) He stated that the Petitioner could not be considered as having reached maximum medical improvement because she had ongoing symptoms for which additional treatment options had not been pursued. (Id.) Dr. Thompson said: "Despite the duration and disabling nature of this condition, at this time Ms. Pierce does not appear to have been satisfactorily evaluated or treated for neurogenic thoracic outlet syndrome."

He recommended further evaluation to rule out other problems, specifically: radiographs of the neck and chest to evaluate for a possible cervical rib, bilateral upper extremity electrodiagnostic testing with nerve conduction velocity/electromyography (NCV/EMG) studies to assess for peripheral neuropathy, and a left anterior scalene and pectoralis minor muscle block to test for TOS. (Id.) Potential treatment options suggested by Dr. Thompson included: physical therapy specifically targeting neurogenic TOS directed and supervised by a therapist with expertise and experience in treatment of TOS; restrictions on upper extremity activity; and pharmacological treatment with muscle relaxants and anti-inflammatories. (Id.) If these treatments improved the Petitioner's symptoms, Dr. Thompson recommended transitioning from physical therapy to occupational therapy. (Id.) If the Petitioner's symptoms did not improve, he would typically recommend surgical thoracic outlet decompression with additional physical therapy and postoperative rehabilitation. (Id.) Regarding work restrictions, Dr. Thompson recommended: no activity with the left arm in an overhead elevated position; limited use in extended positions; no lifting, carrying, pulling or pushing more than 10 pounds; and no prolonged repetitive strain motion including working at a keyboard more than 30 minutes without a break. (Id.)

On January 19, 2019, the Petitioner underwent a Section 12 examination by Dr. Russell Cantrell, a physiatrist at Spine Orthopedics and Rehabilitation. (RX1, Deposition Exhibit B) He reviewed records from the Respondent's onsite clinic (most likely Work Injury Solutions), Dr. McIntosh, NovaCare Rehabilitation, Mt. Vernon Heartland Women's Healthcare Clinic, Dr. Salem, Dr. Raskas, Crossroads Community Hospital and Dr. Thompson. (Id.) Dr. Cantrell took X-rays of the Petitioner's cervical spine that revealed elimination of the usual cervical lordotic curvature with a slight reversal. (Id.) Otherwise, the Petitioner's cervical spine was normal, and she did not appear to have a cervical rib. (Id.) The Petitioner scored a 70 on her DASH survey. (Id.)

Dr. Cantrell opined that the Petitioner's diagnosis could be best described as left trapezial and bilateral scalene myofascial pain and that the work accident neither caused nor contributed to any symptoms that were suggestive of thoracic outlet syndrome. (Id.) He stated that any additional treatment or diagnostic testing would not be necessitated by the work injury. (Id.)

On March 11, 2019, Dr. Cantrell issued a second report after having reviewed Dr. McIntosh's records from Dr. McIntosh's treatment from December 1, 2011, through December 27, 2016. (RX1, Deposition Exhibit C) The records did not alter his prior opinions. (Id.) He issued a third report on August 26, 2019, based on a review of Dr. Crandall's report and stated that evaluation also did not change his opinions. (RX1, Deposition Exhibit D)

At a deposition on August 1, 2019, Dr. Thompson testified consistently with his report. (PX1) He stated that in addition to taking a history from the Petitioner and examining her, he reviewed records from Neuromuscular Orthopedic Institute, Egyptian Spine Clinic, Southern Illinois Imaging, Crossroads Community Hospital, NovaCare Rehabilitation and Dr. Raskas. (Id.)

He testified that a fall onto a shoulder is one of the classic mechanisms of potential injury that could lead to TOS. (Id.)

Regarding the statement in his report that the Petitioner met 10 of the 14 clinical diagnostic criteria in 5 of 5 categories, Dr. Thompson explained that he was referring to diagnostic tools that have been codified into a set of criteria that describe a consensus that experts have felt to be the most important clinical criteria. (Id.) These 14 criteria fall into five different categories based on the description of symptoms, physical examination, other findings that relate to the symptoms and exclusion of other conditions. (Id.) He stated that typically, a strong diagnosis exists when someone has met 7 or 8 of the 14 criteria and 4 out of 5 categories. (Id.) Regarding the Petitioner's DASH score, Dr. Thompson stated that the DASH survey is a commonly used measurement tool to access the level of disability that a patient might have with neurogenic TOS. (Id.)

Dr. Thompson also testified that from the outset of the Petitioner's first medical assessment, the Petitioner exhibited symptoms that would be indicative of TOS. (Id.) He agreed that the fall started the process of the Petitioner's TOS and since then, her work had potentially aggravated her condition. (Id.) Although he was focused primarily on left-sided TOS as a diagnosis, Dr. Thompson acknowledged that he did observe right-sided symptoms and physical examination findings. (Id.) Although he did not think he would have diagnosed TOS on the right side, he stated that his findings were consistent with a compensatory aggravation that could lead to right-sided neurogenic TOS over time, particularly in the absence of treatment for the left side – a phenomenon he commonly observed in his practice. (Id.)

Dr. Thompson did not think he would change his opinions if it was determined that when the Petitioner fell, she had struck any other part of her body on the way to the ground. (Id.) He testified that onset of TOS symptoms can vary from immediate to over a few months. (Id.) He

also stated that pregnancy would not be associated with neurogenic TOS, although carpal tunnel syndrome could be aggravated during pregnancy. (Id.) Regarding Dr. Cantrell's examination in January 2019 that showed a DASH score of 70, Dr. Thompson stated that this score would be consistent with ongoing progression of her condition and worsening of symptoms. (Id.) As to Dr. Cantrell's statement that at best, the Petitioner could have a diagnosis of left trapezial and bilateral scalene myofascial pain, Dr. Thompson testified that statement was a description of symptoms rather than an actual diagnosis. (Id.) Regarding the surgery he recommended, Dr. Thompson said there are probably ten surgeons in the country who treat neurogenic TOS with a high degree of expertise. (Id.)

Dr. Cantrell also testified consistently with his reports at a deposition on September 12, 2019. (RX1) He said it "wouldn't be impossible" for a fall or a blow to the shoulder to cause TOS. (Id.) He said neurogenic TOS is a relatively rare condition in the scheme of the other possible causes of upper extremity numbness and tingling. (Id.) When asked if he performed an EAST test on the Petitioner, Dr. Cantrell stated that was part of his range of motion testing, although he did not specifically reference an EAST test in his report. (Id.)

Of particular significance to Dr. Cantrell in his review of the Petitioner's medical records was that at the time of the work accident, the Petitioner denied having numbness or tingling and did not report these symptoms until she saw Dr. Salem in 2017. (Id.) He stated that the Petitioner had no symptoms within the first month and a half of the injury that would indicate TOS as being traumatically induced. (Id.) He said he would expect symptoms compatible with neurogenic TOS to develop within the first month. (Id.) On cross-examination, he admitted that the Petitioner's complaints early on in her treatment were consistent with TOS, and he didn't note any symptom

magnification by the Petitioner when he examined her. (Id.) He acknowledged that lack of documentation of a symptom does not necessarily mean that the symptom does not exist. (Id,)

Also significant to Dr. Cantrell was that after the accident, the Petitioner had symptoms in her left shoulder, neck and paraclavicular area without any symptoms that were temporally related her right upper extremity, but she at the time of his examination, she presented with bilateral symptoms that would not be consistent with left-sided TOS. (Id.) Another important fact for Dr. Cantrell was that when the Petitioner saw him, she reported she was "doing fine" before that particular incident, but her prior medical records showed she had complained of numbness and tingling in her hands as late as January 2014. (Id.)

Dr. Cantrell disagreed with Dr. Thompson's characterization that left trapezial and bilateral scalene myofascial pain was not an actual diagnosis, analogizing it to a diagnosis of migraine headache, which is an actual diagnosis without having an objective basis for that diagnosis. (Id.) He added that in myofascial pain, there are findings that can be evident on examination beyond subjective complaints, such as palpation of trigger points, assessment for muscle contracture based on limitations in range of motion or positions that provoke or relieve a symptom and postural abnormalities. (Id.)

The Petitioner returned to Dr. McIntosh on February 10, 2020, stating that over the past few years she developed numbness and tingling in her upper extremities and was experiencing sharp pain in the medial aspect of her elbow. (PX4) As stated above, nerve conduction studies were conducted February 19, 2020, and were negative. (PX9) Dr. McIntosh wanted the Petitioner to see a "neck surgeon." (PX4, PX10)

The Petitioner testified that since the March 4, 2015, accident, she had not experienced a day without symptoms in her neck and clavicular area, although some days are better than others.

(T. 34-35) She takes ibuprofen and rests to address her symptoms. (T. 35) She tried getting a massage, but that did not provide long-term relief. (Id.) She said that lifting at work increases her symptoms, and her symptoms make it more difficult to perform her job. (T. 37,) She wants to undergo the injection and therapy recommended by Dr. Thompson. (T. 36)

CONCLUSIONS OF LAW

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

Issue (F): Is Petitioner's current condition of ill-being, specifically alleged neurogenic thoracic outlet syndrome, causally related to the accident?

An accident need not be the sole or primary cause as long as employment is a cause of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n,* 371 ILL. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill. 2d 30, 36 (1982).

The primary question is what is the Petitioner's condition – aside from her shoulder condition to which the parties have stipulated. Dr. Raskas was the first to float the idea in 2017 that the Petitioner suffered from TOS, but this was quickly dismissed, as Dr. Raskas did not believe the condition was causally related to the accident.

Regarding the differing opinions by Drs. Thompson and Cantrell as to whether myofascial pain is a diagnosis or a symptom, it appears that Dr. Thompson is being more technical, in that there is a diagnosis called myofascial pain syndrome, while he is characterizing myofascial pain

itself as a symptom. Regarding the late onset of numbness and tingling and bilateral symptoms that Dr. Cantrell pointed out, Dr. Thompson noted the timing of these symptoms in his report, but this did not appear to affect his opinions. Further, Dr. Thompson explained that the Petitioner's condition of TOS had progressed from the initial injury until these later evaluations.

Both Dr. Thompson and Dr. Cantrell were knowledgeable about TOS and had experience diagnosing and treating the condition. However, Dr. Thompson was more of a true expert in the area, so much so that he heads a department at the Washington University Medical School devoted to that condition. In addition, when comparing the doctors' deposition testimony, Dr. Thompson's testimony was clear and made sense in light of all of the other evidence. Therefore, the Arbitrator gives greater weight to his opinion.

The only question about the mechanism of injury comes from Dr. Raskas, who stated that the Petitioner did not strike the ground. It appears that he may have gotten this information from the commentary of the Respondent's human resources specialist on the injury report. The Petitioner's description of her fall was consistent throughout her treatment and testimony. The Respondent produced no evidence to contradict the Petitioner. She was a credible witness.

Therefore, the Arbitrator finds that the Petitioner's current condition of TOS is causally related to the accident of March 4, 2015.

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

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

There was no challenge to the reasonableness and necessity of the medical treatment the Petitioner received thus far. The Arbitrator incorporates the findings above regarding causation herein.

Because Drs. Raskas and Cantrell found the Petitioner's current condition to be unrelated to the work injury, they did not propose any further treatment. We are left with Dr. Thompson's treatment recommendations, which the Arbitrator finds to be reasonable and necessary to treat the Petitioner's neurogenic TOS, which to date has remained untreated.

Therefore, the Arbitrator finds that the Petitioner is entitled to prospective medical care, specifically further diagnostic testing, injections, therapy and potential surgery as recommended by Dr. Thompson. The Respondent shall authorize and pay for such.

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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC018964
Case Name	MCDONALD, JEFFREY A. v. LAKE COUNTY PRESS, INC.
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	22IWCC0134
Number of Pages of Decision	5
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Larry Appelbaum
Respondent Attorney	Micaela Cassidy

DATE FILED: 4/11/2022

/s/ Thomas Tyrrell, Commissioner

Signature

22IWCC0134

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey McDonald,

Petitioner,

vs. NO: 15 WC 018964

Lake County Press, Inc.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to a remand from the Circuit Court of Lake County in *McDonald, Jeffrey v. Ill. Workers' Comp. Comm'n*, 19 MR 1192, entered November 18, 2020.

I. Procedural Background

Petitioner previously appealed the December 6, 2019 Decision of the Commission finding that Petitioner did not sustain an accidental injury arising out of and in the course of his employment with Respondent. On November 18, 2020, Judge Melius of the Circuit Court of Lake County issued an order finding that Petitioner's injuries on March 3, 2015, arose out of and in the course of his employment. He remanded this case to the Commission for a determination of benefits.

II. Findings of Fact

The Commission hereby incorporates by reference the findings of fact contained in the Arbitration Decision to the extent it does not conflict with the Circuit Court's opinion dated November 18, 2020. Any additional findings of fact in this Decision and Opinion on Remand will be specifically identified in the discussion of particular issues.

III. Conclusions of Law

The Commission hereby finds that Petitioner sustained an accident that arose out of and in the course of his employment on March 3, 2015. The Commission now finds that Petitioner's condition of ill-being to the left ankle and DVT were causally-related to said accident, and he is

entitled to reasonable and necessary medical expenses, temporary total disability, and permanent partial disability for the reasons stated herein, and 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.

A. Temporary Total Disability Benefits (TTD)

Petitioner underwent surgical repair of his left Achilles' tendon rupture by Dr. Waxman on October 1, 2015. He did not lose any time from work due to the accident prior to this date. The parties stipulated that Petitioner was temporarily totally disabled through October 18, 2015. Petitioner testified to same. (T. 44-45). Accordingly, the Commission concludes that Petitioner is entitled to TTD benefits from October 1, 2015 through October 18, 2015, a period of 2-4/7 weeks.

B. Reasonable and Necessary Medical Expenses

Petitioner submitted reasonable and necessary medical expenses detailed in PX5 through PX10, totaling $18,533.64. All medical expenses submitted carry zero balances after payments made by group insurance (Aetna). The proper award of medical expenses is the amount actually paid to the medical service providers, or the fee schedule, whichever is less. *Perez v. Ill. Workers' Comp. Comm'n*, 2018 IL App (2d) 17086WC, 96 N.E.3d 524, 420 Ill. Dec. 439 (2018).

With regards to PX5 (North Sheridan Family Medicine – Dr. Gorelik), treatment through June 3, 2015 was reasonable and necessary and causally related to the accident. Aetna paid $524.63 for services between March 16, 2015 and June 3, 2015.

With regards to PX6A&B (NorthShore University) Aetna paid $1,760.76 for services on March 5, 2015 and $85.90 for services on June 3, 2015.

With regards to PX7-9 (Illinois Bone & Joint Institute), the parties stipulated the bills contained unrelated charges for the shoulder for which Respondent is not liable. For PX7, Aetna paid $1,953.77 for treatment related to the accident. For PX8, Aetna paid $566.10 for treatment related to the accident. For PX9, Aetna paid $3,611.63 and Petitioner paid $286.55 out-of-pocket.

With regards to PX10 (Ravine Way Surgery Center), Aetna paid $7,596.75 and $2,147.55.

C. Permanent Partial Disability Benefits (PPD)

As the date of accident (3/3/2015) occurred after the effective date of the amendment (9/1/2011), an analysis pursuant to §8.1b of the Act is necessary. The Act specifically states that "… [n]o single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." §8.1b(b).

(i) The reported level of impairment

No impairment rating was submitted. This factor is accorded no weight.

(ii) The occupation of the injured employee

Petitioner worked as an electronic prepress operator at the time of the accident, and still works in that position. This is primarily a sedentary job. This factor is accorded lesser weight.

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

Petitioner was 59-years-old at the time of the accident. This factor is accorded moderate weight.

(iv) The employee's future earning capacity

There was no evidence that this injury has affected Petitioner's future earning capacity. As a result, this factor is accorded no weight.

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

Petitioner sustained a DVT and left Achilles' tendon rupture as a result of his injury on March 3, 2015. In addition to be followed in anticoagulation therapy for his DVT, Petitioner also underwent surgical repair of the left Achilles' tendon with excision Haglund deformity and FHL tendon transfer. (PX4). At his last visit with Dr. Waxman on January 11, 2016, swelling was noted and compression stocking was recommended. (PX4).

Petitioner testified his left ankle swells and he experiences pain at times, with cramps in the calf area, and a limp. (T. 45). He wears different shoes than he did before the accident, to allow for a little swelling in the afternoon. *Id.* When golfing he rides in a cart versus walking. He no longer skis, plays racquetball, or lifts weights, as he finds that use of the left leg causes swelling and cramping. (T. 45-46). He noted difficulty descending stairs, and tries to utilize the elevator when available. (T. 47). Finally, he testified that others have indicated he has a limp, which becomes more pronounced by the end of a workday. (T. 47-48).

Petitioner's evidence of disability is corroborated by the treating medical records. This factor is accorded greater weight.

In consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency and after considering all of the evidence adduced, the Commission finds that, as a result of the injuries sustained, Petitioner suffered permanent partial disability to the left foot to the extent of 25% loss of use thereof, pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 6, 2017, is hereby reversed regarding accident, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Petitioner's condition of ill-being regarding his left ankle and DVT knee are causally related to the March 3, 2015 work accident.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $714.71/week for 2-4/7 weeks, commencing October 1, 2015 through October 18, 2015, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical expenses of $18,533.64, subject to §8(a)/§8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall receive a credit in the amount of $6,454.21 for related payments made by the group health insurer, pursuant to Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED that Respondent pay to Petitioner the sum of $643.26 per week for a period of 38.75 weeks, as provided in § 8(e) of the Act, for the reason that the injury sustained caused the loss of use of 25% of the left foot.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $51,600.00. 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.

April 11, 2022

o: 02/15/2022
TJT/ahs
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC028911
Case Name	STOCKING, CHASTIDY v. L.W. SCHNEIDER, INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0135
Number of Pages of Decision	16
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Laura Hall
Respondent Attorney	Grace Di Gerlando

DATE FILED: 4/11/2022

/s/Carolyn Doherty, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHASTIDY STOCKING,

Petitioner,

vs. NO: 19 WC 28911

L.W. SCHNEIDER, INC.,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2021, 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.

April 11, 2022

o: 4/07/2022
CMD/ma
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC028911
Case Name	STOCKING, CHASTIDY v. LW SCHNEIDER, INC
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Jessica Hegarty, Arbitrator

Petitioner Attorney	Laura Hall
Respondent Attorney	Grace Di Gerlando

DATE FILED: 7/16/2021

THE INTEREST RATE FOR THE WEEK OF JULY 13, 2021 0.05%

/s/ Jessica Hegarty, Arbitrator
Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Chastidy Stocking
Employee/Petitioner

v.

L W Schneider, Inc.
Employer/Respondent

Case # **19** WC **28911**

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **4/30/2021**. After reviewing all 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, **11/9/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**58,806.80**; the average weekly wage was $**1,130.90**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $**4,148.57** for TTD, $**0** for TPD, $**0** for maintenance, and $**20,388.84** for other benefits, for a total credit of $**24,537.41**.

Respondent is entitled to a credit of $**9,634.88** under Section 8(j) of the Act.

ORDER

- **The Petitioner did sustain a work-related accident resulting in injury to her left wrist/elbow sprain/strain on November 9, 2018. The Arbitrator finds no causal connection between the Petitioner's current condition and her injury of November 9, 2018.**
- **The Arbitrator denies any and all medical expenses incurred by the Petitioner after April 18, 2019 and, also, denies and claimed TTD benefits.**
- **The Respondent will receive a credit for all medical bills paid by the group carrier under Section 8(j) of the Act as stipulated to at the time of trial (i.e. $9,634.88).**
- **Respondent will be given a credit for medical paid (i.e. $20,388.84) and for non-occupational disability benefits paid (i.e. $4,148.57). (RX 3)**
- **As the Arbitrator finds no causal connection between the Petitioner's injury and her treatment post April 18, 2019, all medical care post said date is denied, including prospective medical care.**

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

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

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

Jason A. Hoyt

Signature of Arbitrator

JULY 16, 2021

ICArbDec19(b)

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

On April 30, 2021, this matter proceeded to hearing before the Arbitrator at the Illinois Workers Compensation Commission in Chicago, Illinois. (Arb. 1)

On her alleged accident date, November 9, 2018, the Petitioner, Chastidy Stocking, was employed by the Respondent, L.W. Schneider, and had been so employed for approximately 8 years. The Petitioner testified she was employed as a cell coordinator (Transcript p.7, hereinafter Tx.7). Respondent makes parts for guns, specifically AR-15's. (Id).

According to her testimony regarding her alleged accident date, the right-handed Petitioner was "wheeling" parts which entailed taking a 20 to 25-pound box of parts, piece by piece, and holding each piece against a hard wheel to ensure dents and scratches are removed. (Tx. 8-9, 47). When finished, she picked up the box and felt something "pop or pull" in her left shoulder. (Tx. 9). She felt a little pain when this occurred and noticed swelling from her left wrist to her left elbow. (Tx. 9-10). Petitioner reported the incident to her supervisor, Evan Cox and finished her shift. (Tx. 11). After she arrived home, the Petitioner observed purple and red bruising to the inside of her left forearm. (Tx. 10).

On November 10, 2018, the Petitioner was evaluated by physician's assistant Jennifer Gutshall at St. Margaret's Health. She presented with "intermittent left forearm pain and tingling in the left hand...," which she first noticed the preceding day, but she couldn't "recall any specific trauma or injury." Reportedly, her pain began while she was at work, but, again, no incident or injury was reported. She complained of numbness and tingling down into the arm. Reportedly, the pain shot "from her left inner wrist up into the forearm," but she denied elbow pain. X-rays of the left forearm were normal. Following her evaluation, the Petitioner was diagnosed with left arm pain, numbness and tingling. A Toradol injection was administered and a wrist cock-up splint prescribed along with a Medrol Dosepak. Light duty work restrictions were imposed. (PX 2)

On November 13, 2018, the Petitioner was evaluated by Dr. Robert Mestan, her family doctor. Reportedly, she was carrying boxes at work on Saturday when she began experiencing severe left forearm and hand pain. She also complained of numbness and tingling of the left hand. Dr. Mestan assessed the Petitioner with a forearm injury and Tylenol-Codeine was prescribed along with a left forearm MRI. (PX 3)

On November 15, 2018, the Petitioner was evaluated by Dr. Allen Van of the Perry Memorial Orthopedic Clinic. She complained of left forearm discomfort and pain, which had been ongoing for one week. The Petitioner did "not recall any significant 1 singular event," but performed a lot of lifting and using her upper extremity at work. Dr. Van diagnosed the Petitioner with a left forearm sprain and possible palmaris longus rupture. Conservative management was recommended with light duty work and physical therapy. (PX 5)

On November 27, 2018, the Petitioner underwent a left forearm MRI, which reportedly did not exhibit any abnormality to explain her symptoms. (PX5)

On December 14, 2018, the Petitioner returned to Dr. Van. Reportedly, **s**he was doing well and making a good gradual recovery in therapy. Her left forearm pain was much improved, and she was released to resume full duty work. The Petitioner was advised to complete therapy. (PX 5)

On December 19, 2018, the Petitioner returned to Dr. Mestan who noted that on November 9th, the Petitioner was at work grinding parts on a wheel when she began experiencing pain, numbness and color changes to the right hand and forearm. Upon examination, the Petitioner's left hand was "slightly dusky" compared to the right, but there was good pulse and normal sensation. Dr. Mestan assessed the Petitioner with RSD and Gabapentin was offered, but declined, and an EMG was prescribed. (PX 3)

On January 28, 2019, the Petitioner underwent EMG/NCV testing at the Illinois Neurological Institute. Reportedly, she began to notice some purplish discoloration and pain in the left hand on November 9, 2018. "There was no history of any injury or trauma." Per Dr. Lisa Snyder, the EMG/NCV test results were normal. (PX 3 & 6) On February 1, 2019, the Petitioner underwent a US left duplex upper extremity exam, which was reportedly normal. (PX 10)

On February 8, 2019, the Petitioner returned to Dr. Mestan with continued complaints of tingling pain in the left forearm. Reportedly, there was "no trauma though she feels it's from the work she does." Dr. Mestan again assessed the Petitioner was assessed with RSD of the upper limb and Gabapentin was prescribed. (PX 3)

On February 18, 2019, the Petitioner returned to Dr. Van. Reportedly, she was on Gabapentin and her numbness had improved and she had returned to her regular job. The Petitioner complained of occasional stiffness of the sprained wrist, but overall, she was making steady progress. Examination revealed full painless range motion at the elbow and wrist. Dr. Van noted that there were no signs of any significant redness sinus to the skin or severe sensitivity to light touch throughout the left upper extremity. According to Dr. Van, there was no evidence of reflex sympathetic dystrophy to the Petitioner's left upper extremity and she was assessed with a resolved left forearm sprain and placed at MMI. (PX 5)

On February 19, 2019, the Petitioner returned to Dr. Mestan. She reported definite improvement with Gabapentin, and it was noted that her tingling was gone. Dr. Mestan assessed the Petitioner with a forearm sprain and RSD and advised her to increase her Gabapentin. (PX 3)

On March 1, 2019, the Petitioner was evaluated at the Illinois Neurological Institute (upon the referral of Dr. Mestan) due to numbness and tingling in her left arm. The Petitioner alleged that after working in November, her arm was purple and hurt and her hand was swollen. She alleged that her hand turned purple sometimes and when she moved it, she would experience tingling and numbness with a shooting pain down the inside of the upper arm. Reportedly, Gabapentin made her sleepy and she did not feel like it was helping. Upon examination, the extremities were noted to be normal with no edema or discoloration of the hands. Strength was reportedly full and sensation intact. Following her evaluation, the Petitioner's Gabapentin was decreased due to side effects and a cervical MRI ordered due to the Petitioner's numbness and tingling. Blood work was also ordered. (PX 6)

On March 26, 2019, the Petitioner underwent a cervical MRI, which exhibited no spinal cord abnormality, no acute fracture or subluxation, and no cerebellar tonsillar herniation. Reportedly, there was mild cervical spondylosis and degenerative disc disease. (PX 6)

On April 2, 2019, the Petitioner returned to Dr. Mestan. Reportedly, her left arm pain had resolved, and she was doing well without complaint. The Petitioner was released from care and Dr. Mestan noted that no further treatment was needed. (PX 3)

On April 18, 2019, the Petitioner returned to the Illinois Neurological Institute. Her labs were noted to be unremarkable, arterial studies showed good blood flow and her cervical MRI exhibited some arthritis. Examination revealed 5/5 muscle strength throughout, sensation was intact, and no discoloration of the hands was noted. The

Petitioner was assessed with numbness and tingling of the left arm and advised to sleep with her arms in a neutral position instead of bent overhead. She was released to follow up on an as needed basis. (PX 6)

On September 10, 2019, the Petitioner returned to Dr. Mestan with complaints of left arm pain since "doing a different job at work requiring repetitive use of left arm." Reportedly, her arm felt swollen, numb and painful. Upon examination, the Petitioner's left arm appeared normal. There was no tenderness, no color change, and normal strength. It was noted that the Petitioner complained of pain when Dr. Mestan put her left shoulder and arm through range of motion. A Medrol Dosepak was prescribed. On September 18, 2019, Dr. Mestan prescribed Gabapentin and physical therapy. (PX 3)

On September 20, 2019, the Petitioner returned to Dr. Van. Allegedly, on November 9, 2018, the Petitioner went to pick up a box at work when she felt sharp pain in her left shoulder into her fingertips. The Petitioner complained of aches and pains and diffuse pressure throughout her forearm. Reportedly, her work-up to date had been negative and she was being referred to evaluate and treat for possible underlying CRPS. Upon examination, Dr. Van noted that the Petitioner exhibited full, painless range of motion of the left shoulder, elbow, and wrist. There was no evidence of any skin mottling, no hyper or perfuse sweating to the skin of the forearm or upper arm and no signs of atrophy. EMG and MRI of the forearm were noted to be within normal limits. Dr. Van assessed the Petitioner with a forearm sprain and noted that his evaluation of her was within normal limits. From an orthopedic standpoint, Dr. Van noted that he had nothing more to add. In Dr. Van's opinion, the Petitioner should complete a course of physical therapy (4-6 weeks) and "that should be the end of her treatment and she will have reached MMI." (PX 5)

On September 25, 2019, the Petitioner returned to Dr. Mestan. Reportedly, there was no change in her chronic left arm pain, and she was now experiencing pain in the left shoulder with popping. The Petitioner was diagnosed with a forearm sprain, left shoulder pain and RSD of the upper limb. A left shoulder MRI and physical therapy were prescribed. (PX 3)

On October 1, 2019, the Petitioner underwent a left shoulder MRI, which exhibited a less than 50% partial-thickness partial width supraspinatus intrasubstance tear and low-grade strain. There was also noted to be mild subscapularis tendinosis. (PX 4)

On October 1, 2019, the Petitioner underwent a cervical MRI, which exhibited mild cervical spondylosis and degenerative disc disease, but no significant narrowing. (PX 4)

On October 3, 2019, the Petitioner was evaluated by Dr. John Ibrahim. Reportedly, she had a history of a work-related upper extremity injury and presented due to severe shoulder pain for the "last couple of months." It was noted that she was also experiencing color and temperature changes of the left arm. Dr. Ibrahim assessed the Petitioner with left shoulder pain. Physical therapy was prescribed, and the Petitioner was advised to continue with Gabapentin, Lidocaine patch and Diclofenac gel. She was also referred to an ortho "given the new shoulder MRI finding" and she reportedly had an appointment to see a neurologist at Northwestern due to CRPS. (PX 3)

On October 9, 2019, the Petitioner returned to Dr. Mestan and it was noted that she was "now complaining of left shoulder pain." She was advised to continue with therapy, work restrictions and to keep her appointment with the ortho. Her medications were continued. (PX 3)

On October 11, 2019, the Petitioner returned to Dr. Van. Upon examination, the Petitioner was noted to have full range of motion of the left elbow and shoulder. She also had good wrist extension and intrinsics with no evidence of any radicular symptoms or atrophy of the left upper extremity. Dr. Van noted that there were "no signs of clinical stigmata of RSD" that he could appreciate, and the rest of the Petitioner's examination was unremarkable.

Reportedly, there was full strength of the left upper extremity and rotator cuff. Dr. Van reviewed the MRI report and recommended that the Petitioner complete physical therapy for her forearm sprain and, at the end of the same, Dr. Van opined that she would be at MMI. According to Dr. Van, no further evaluations or workup were necessary, and, from an orthopedic standpoint, the Petitioner was released to return full duty work. (PX 5)

On October 15, 2019, Dr. Mestan authorized the Petitioner off of work until she saw a specialist. Nabumetone was prescribed. (PX 3)

On October 29, 2019, the Petitioner was evaluated by Dr. Guido Marra relative to her left shoulder pain. The Petitioner reported originally injuring her left shoulder on November 9, 2018 while lifting a 20-pound box and feeling a pop in her arm with pain in her shoulder. Upon examination, the Petitioner was noted to have pain on the anterior aspect of the shoulder and diffuse numbness and tingling throughout her arm, but no hypersensitivity to her skin. Dr. Marra reviewed the Petitioner's MRI and noted that it did not exhibit any signs of obvious rotator cuff pathology. The Petitioner was assessed with chronic left shoulder pain and a MR arthrogram was prescribed. (PX 7)

On October 30, 2019, the Petitioner returned to Dr. Mestan and continued to complain of left arm pain, which was now mainly in her shoulder. The Petitioner was assessed with left shoulder pain, advised to continue with therapy, and authorized off of work. (PX 3)

On November 15, 2019, the Petitioner underwent a left shoulder MRI arthrogram, which exhibited a partial thickness supraspinatus tear, but no evidence of a full thickness tear or of a labral tear. (PX 4)

On November 26, 2019, the Petitioner returned to Dr. Marra. Reportedly, she was being followed for impingement syndrome of her left shoulder and had been attending physical therapy with some modest improvement. She continued to complain of pain on the superior aspect of her shoulder. Dr. Marra assessed the Petitioner with a left partial-thickness rotator cuff tear. She was advised to continue with physical therapy and a steroid injection was administered. The Petitioner was authorized off of work through December 9, 2019. (PX 7)
On November 27, 2019, the Petitioner returned to Dr. Mestan reporting that her arm pain had improved and she would be returning to work on December 9th. She complained of mild left shoulder pain. The Petitioner was assessed with a rotator cuff tear and Gabapentin was prescribed. She was to follow up "only if needed." (PX 3)

On December 23, 2019, the Petitioner underwent repeat EMG/NCV testing at Northwestern. Reportedly, the EMG/NCV results were normal. (PX 7)

On January 9, 2020, the Petitioner returned to Dr. Marra. Reportedly, she had undergone physical therapy and cortisone injection, but her pain remained the same from her shoulder down into her biceps and into the medial aspect of her arm into her hand. The Petitioner complained of numbness, discoloration, and swelling of the hand. Upon examination, strength was noted to be 5/5 and Hawkin's, Neer's, crossover, Speeed's and O'Brien's testing were negative. Reportedly, the Petitioner was taking Gabapentin. After evaluating the Petitioner, Dr. Marra noted that she may have CRPS of the left upper extremity and he referred her to a pain specialist. She was released to return to full duty work and advised to follow up with Dr. Marra on an as needed basis. (PX 7)

On February 27, 2020, the Petitioner was evaluated by Dr. Belavic of the Elmhurst Hospital Center for Pain Management. The Petitioner alleged that in November of 2018, while wheeling parts on a "hard wheel," she went to lift a box and felt a "pop/pull to her upper left shoulder area." Allegedly, when she got home, she noticed extensive bruising to the left wrist. After evaluating the Petitioner, Dr. Belavic opined that the Petitioner's residual left arm and hand symptoms were consistent with "sympathetic dysfunction/early chronic regional pain syndrome type I."

Dr. Belavic recommended that she proceed with a diagnostic/therapeutic stellate ganglion block and, based upon the results, a possible series of blocks. Capsaicin cream and Elavil were prescribed, and the Petitioner was advised to continue use of Gabapentin. (PX 8)

On June 3, 2020, the Petitioner underwent a left stellate ganglion block on June 3, 2020. (PX 9)

On June 19, 2020, the Petitioner returned to Dr. Belavic's office. Reportedly, she noticed 100% improvement the day of the procedure, but her pain returned "last week." Later it was noted that she received relief from the injection for one day. It was recommended that the Petitioner proceed with a repeat injection, but performed in a series and that she use Gabapentin during the day. (PX 8)

On July 30, 2020, the Petitioner underwent an independent medical examination with Dr. Richard Noren. She reported that she was initially injured on November 9, 2019 when she felt a pop in her left shoulder while lifting a box weighing approximately 20 to 25 pounds. The Petitioner's medical history was reviewed, and she reported that her current pain was in her shoulder to her fingers and involved her whole hand. She also reported a pressure sensation most severe over her biceps. The Petitioner noted sensitivity to cold, but denied any hot or sweaty sensations. Air conditioning allegedly increased her pain, but air blowing on her arm or water from the shower did not change her symptoms or increase her pain. She denied any hair or nail changes, but reported that her upper extremity turned dark red at times; however, the aforementioned was no longer noticeable due to her tan. It was noted that the Petitioner was currently working full duty, part time, performing kitchen work (i.e. 15 hours per week), which included waitressing, making pizzas, and delivering pizzas. (RX 1)
Upon examination, the Petitioner's sensation was noted to be intact to pinprick and light touch. She had no allodynia and no hyperalgesia in the left upper extremity or shoulder. Strength was 5/5. Examination of both upper extremities reportedly revealed no visible edema, no hair or nail changes and no color changes. Temperature measurements noted the left hand 32.2 degrees; right hand 33 degrees; left biceps 32.8 degrees; right biceps 31.9 degrees; left shoulder 32.4 degrees; and, right shoulder 32.5 degrees. Per Dr. Noren, the Petitioner's history and examination took 44 minutes. (RX 1)

After evaluating the Petitioner, Dr. Noren opined that the Petitioner did not have CRPS and her current diagnosis was likely unrelated to the incident of November 9, 2018. According to Dr. Noren, the Petitioner's symptoms, which initially involved her left forearm and now involved the shoulder, were inconsistent with her reported injury. Additionally, Dr. Noren noted that the Petitioner's reported injury had changed with multiple physician visits (i.e. allegedly when lifting boxes, when working at machines, uncertain as to how it started). Dr. Noren noted that at no time throughout her records and the examinations of Dr. Belavic, Dr. Marra, Dr. Mestan, the Neurology Clinic and Dr. Snyder did the Petitioner's physical examinations meet the Budapest criteria for CRPS. Dr. Noren opined that the Petitioner did not have nor did she ever have CRPS. In Dr. Noren's opinion, the Petitioner's current complaints likely represented a forearm strain. According to Dr. Noren, the Petitioner's shoulder symptoms may be related to a shoulder injury; however, records "do not appear to reflect that this is related to the history provided to multiple physicians prior to seeing Dr. Marra in terms of relation to the injury of November of 2018." At this evaluation, the Petitioner reported that she was lifting a box on November 9, 2018 and felt a pop in her left shoulder, but records appear to reflect that her initial complaints were to her left forearm. In Dr. Noren's opinion "it would not appear… that her symptoms are related to an injury that occurred on November 9, 2018." (RX 1)

Dr. Noren opined that the Petitioner's symptoms were non-neuropathic, musculoskeletal in origin and inconsistent regarding the relationship to her reported injury of November 9, 2018. From a pain management perspective, Dr. Noren noted that she did not require any further treatment for her alleged work accident and the Petitioner was at MMI. Dr. Noren opined that additional stellate ganglion blocks were not indicated and there were not any

sympathetic features to the Petitioner's pain that would require those injections. Additionally, Dr. Noren opined that the Petitioner was taking a sub-therapeutic dose of Neurontin (Gabapentin) and there was no indication for the use of the same. Dr. Noren noted that the possibility that the Petitioner's subjective complaints were related to a left shoulder injury could not be excluded and he deferred to Dr. Marra relative to the same. From a pain management perspective, Dr. Noren opined that the Petitioner had not sustained any permanent impairment and she had no physical impairments on exam that would be related to a reported injury of November 9, 2018. Again, Dr. Noren opined that the Petitioner's current pain complaints were unrelated to CRPS and were non-neurologic. (RX 1)

On September 15, 2020, the Petitioner returned to Dr. Mestan for a refill of her Gabapentin. Reportedly, her left arm pain was controlled with use of the same. (PX 3)

The Petitioner testified that she stopped working for the Respondent on December 19, 2019 because she was suspended after being accused of theft. Her suspension ultimately led to her termination at which point she lost her health insurance benefits. Since that time, the Petitioner testified that she had been unable to seek medical care. She testified that she was last seen by a physician, by Dr. Mestan, on September 15, 2020 and that she wished to continue with medical treatment. (TX 29-31)

The Petitioner testified that she never had any issues or injuries to her left shoulder, arm, wrist, or hand prior to November 9, 2018. She testified that she had never experienced numbness, tingling, color changes or swelling to her left upper extremity prior to that time.

The Petitioner testified that Petitioner's Group Exhibit 11 was a series of photos, which exhibited the swelling and redness to her left hand. She testified that the photos were taken at work by a girl named Angel. The Petitioner did not recall the date that the photos were taken, but testified that they were taken some time between November 9, 2018 and December of 2020. (TX 31-34)

CONCLUSIONS OF LAW

(C) ACCIDENT

Although the Petitioner consistently reported an injury occurring on November 9, 2018, she reported various mechanisms of injury to various providers and did not report any injury to her left shoulder until approximately 10 months after her alleged injury of November 9, 2018.

At her initial medical visit, on November 10, 2018, the Petitioner reported that she first noticed her symptoms the preceding day, but that she could not "recall any specific trauma or injury." Allegedly, her pain began while she was at work, but, again, no incident or injury was reported. On November 13, 2018, the Petitioner advised Dr. Mestan that she began experiencing severe pain in her left forearm and hand, while carrying boxes at work. Just two days later, on November 15, 2018, the Petitioner advised Dr. Van that she did not recall any singular one event that led to her left forearm discomfort and pain. On December 19, 2018, the Petitioner then informed Dr. Mestan that her pain began when she was at work grinding parts on a wheel. On January 28, 2019, the Petitioner underwent EMG/NCV testing and again reported no history of injury or trauma. On February 8, 2019, Dr. Mestan's report again references "no trauma" though the Petitioner "feels it's from the work she does." In a matter of approximately two months, the Petitioner went from not recalling any injury or trauma to her left upper extremity, to being injured carrying boxes, back to having no injury, on to injuring herself while grinding parts at work and

then back to experiencing no injury to trauma. At no point during this time period did the Petitioner report any injury to her left shoulder.

By mid-April of 2019, the Petitioner was released from care by all of her treating physicians relative to her alleged injury of November 9, 2018. Following her release, the Petitioner did not return for care again until September 10, 2019. Interestingly, when the Petitioner returned for care in September of 2019, her mechanism of injury changed as did the body part that was allegedly injured.

On September 10, 2019, the Petitioner was seen by Dr. Mestan and complained of left arm pain since "doing a different job at work requiring repetitive use of left arm." The Petitioner returned to Dr. Van on September 20, 2019, and reported that, on November 9, 2018, she went to pick up a box when she felt sharp pain in her left shoulder. On October 3, 2019, the Petitioner informed Dr. Ibrahim that she suffered from severe shoulder pain for the "last couple of months." The Petitioner's mechanism of injury changed yet again on October 29, 2019, when she informed Dr. Marra that she injured her left shoulder while lifting a 20-pound box. In February of 2020, the Petitioner informed Dr. Belavic that she went to lift a box at work in November of 2018, when she felt a "pop/pull to her upper left shoulder area." Finally, on July 30, 2020, the Petitioner also informed Dr. Noren that she was initially injured on November 9, 2018 when she was lifting a box weighing approximately 20 to 25 pounds and felt a pop in her left shoulder. The Arbitrator notes that by September of 2019, 10 months after the Petitioner's alleged injury, the Petitioner's alleged mechanism of injury morphed into an entirely different being. Additionally, the Arbitrator specifically notes that the Petitioner never alleged a shoulder injury pre- September of 2019 nor did she ever allege lifting a box and experiencing a "pop" in her left shoulder pre-September of 2019.

At the time of trial, the Petitioner testified that when she was done wheeling parts on November 9, 2018, she went to pick up a box that weighed 20 to 25 pounds and felt something pop or pull in her left shoulder. The Arbitrator finds the aforementioned testimony was to be a clever attempt at tying the differing mechanisms of injury together and she find the Petitioner's testimony to be incredulous. Mr. Keske testified that on approximately November 12, 2018, the Petitioner advised him that her wrist was hurting and that the Petitioner believed that repetitive motion, reworking parts/components, and excessive work hours were causing her pain. He testified that he did not recall the Petitioner ever reporting a left shoulder injury or reporting that she was injured while lifting a box. Mr. Keske reiterated that the Petitioner reported injuring herself while reworking parts.

Although she reported various mechanisms of injury to various providers and did not report any injury to her left shoulder until approximately 10 months after her alleged injury of November 9, 2018, Petitioner consistently reported an injury occurring on November 9, 2018.

Based on a preponderance of the credible evidence, the Arbitrator finds that Petitioner has proven that she sustained, at most, a left wrist/elbow sprain/strain as a result of her job duties that involved grinding parts on November 9, 2018. The Petitioner failed to prove by a preponderance of the credible evidence that she sustained an injury to her left shoulder on that date.

(F) CAUSAL CONNECTION

Although the Arbitrator found that the Petitioner suffered from an accident to her left upper extremity on November 9, 2018, the Arbitrator finds no causal connection between said accident and the Petitioner's condition and medical care after April 18, 2019. In so finding, the Arbitrator notes that all of the Petitioner's treating physicians had released her from care as of April 18, 2019. Furthermore, when the Petitioner resumed care in September of 2019, both the mechanism of injury and the alleged body part injured had changed.

On February 18, 2019, Dr. Van, an orthopedic surgeon, assessed the Petitioner with a resolved left forearm sprain and placed the Petitioner at maximum medical improvement. According to Dr. Van, the Petitioner was making steady progress and there were no signs of any significant redness to the skin or severe sensitivity to light touch throughout the left upper extremity. At that time, Dr. Van opined that the Petitioner exhibited no evidence of reflex sympathetic dystrophy.

On February 19, 2019, Per Dr. Mestan noted that the Petitioner's tingling had resolved and, on April 2, 2019, Dr. Mestan noted that the Petitioner's left arm pain had also resolved. Reportedly, at that time, the Petitioner was doing well without complaint. She released from Dr. Mestan's care on April 2, 2019.

Finally, on April 18, 2019, the Petitioner was released from care at the Illinois Neurological Institute. Examination at said facility revealed full strength throughout, intact sensation and no discoloration of the hands. The Petitioner was assessed with numbness and tingling of the hands and advised to sleep with her arms in a neutral position instead of bent overhead.

Although the Petitioner, by her testimony, would have one believe that her symptoms and pain continued from the date of her injury through the date of her trial, her medical records contradict that contention. Additionally, although the Petitioner testified that she was assessed with CRPS while at the Illinois Neurological Institute, her medical records reflect no such thing. In fact, the only physician to assess her with CRPS pre-September of 2019 was Dr. Mestan, a family physician, who is arguably less qualified to provide such a diagnosis than Dr. Van (an orthopedic surgeon), Dr. Noren (a pain management physician) or a neurologist at the Illinois Neurological Institute. Furthermore, all physicians, including Dr. Van, released the Petitioner from care relative to her November 9, 2018 injury by April 18, 2019.

The Arbitrator notes that post April 18, 2019, the Petitioner did not seek care again until September 10, 2019. The Arbitrator finds the Petitioner's delay in treatment from April of 2019 through September of 2019 to be a significant gap in treatment, especially due to the fact that the Petitioner's alleged mechanism of injury changed post her release from care in April of 2019. Based upon the facts of this case, the Arbitrator finds no causal connection between the Petitioner's condition of ill being post April 18, 2019 and her alleged injury of November 9, 2018.

Prior to September of 2019, the Petitioner made no complaints of left shoulder pain nor did she ever report lifting a box and feeling a pop in her shoulder prior to that time. On September 10, 2019, the Petitioner advised Dr. Mestan that she "doing a different job at work requiring repetitive use of left arm" and this resulted in shoulder pain. At no point in time did the Petitioner testify to any job changes at the time of trial nor did she inform any physician (other than Dr. Mestan) that her job duties had changed. In September of 2019, the Petitioner complained of pain when her left shoulder was put through range of motion. (PX 3)

After September of 2019, the Petitioner informed Dr. Van, Dr. Marra, Dr. Belavic and Dr. Noren that she injured her left shoulder while picking up a box. Again, the Arbitrator notes that for 10 months this mechanism of injury was never reported to any treating physician nor did the Petitioner ever complain of shoulder pain. Based upon the aforementioned, the Arbitrator finds the Petitioner's reported mechanism of injury post September of 2019 to be false and unreliable. Furthermore, the Arbitrator notes no injury or diagnosis to the left shoulder pre-September of 2019. As such, the Arbitrator finds no causal connection between the Petitioner's injury of November 9, 2018 and her diagnoses or treatment post April 18, 2019.

Additionally, the Arbitrator finds no causal connection between the Petitioner's alleged CRPS and her injury of November 9, 2018. In so finding, the Arbitrator finds the opinions of Dr. Van and Dr. Noren to be more credible than those of Dr. Mestan and Dr. Belavic. In his examination findings, Dr. Van references specific findings that

would contradict a finding of CRPS (i.e. no severe sensitivity to light touch, no significant redness to the skin). Additionally, during the Petitioner's last examination at the Illinois Neurological Institute in April of 2019, she was noted to have no discoloration of the hands, no edema, and full sensation. At that time, the Petitioner's extremities were noted to be normal. The Arbitrator notes that even Dr. Mestan's report of April 2, 2019 references no left arm pain and no complaints. Furthermore, Dr. Noren opined that at no point did the Petitioner's physical examination findings meet the Budapest criteria for CRPS.

Dr. Noren noted that the Petitioner's sensation was intact to pinprick and light touch, there was allodynia and no hyperalgesia in the left upper extremity or shoulder. Strength was 5/5 and examination of both upper extremities revealed no visible edema, no hair or nail changes and no visible color changes. Temperature measurements were left hand 32.2 degrees; right hand 33 degrees; left biceps 32.8 degrees; right biceps 31.9 degrees; left shoulder 32.4 degrees; and, right shoulder 32.5 degrees. Per Dr. Noren, the Petitioner's history and examination took 44 minutes, which directly contradicted the Petitioner's allegation that Dr. Noren merely spent 10 to 15 minutes with her.

Additionally, the Arbitrator finds it significant that although the Petitioner testified to the discoloration of her left upper extremity, she failed to show her arms or hands at trial and wore long sleeves during the same. Petitioner's Group Exhibit #11 was purported to exhibited the discoloration of the Petitioner's skin; however, the Arbitrator noticed no discoloration exhibited and makes special note of the fact that the Petitioner was unable to credibly testify as to where and when the photographs were taken. As such, little weight is placed on the photographic evidence admitted as Petitioner's Group Exhibit #11.

Critical to the determination of causal connection is the Petitioner's credibility and the weight of her testimony depends upon the same.

Although the Arbitrator has already provided several bases for finding that the Petitioner's condition subsequent to April of 2019 was not causally related to her work injury, the Arbitrator notes certain significant discrepancies in the Petitioner's testimony and her medical records. Again, at the time of trial, the Petitioner testified that she went to pick up a box when she felt a pop in her left shoulder, which is inconsistent with the mechanism of injury contained within her contemporaneous medical records.

The Arbitrator also finds it significant that the Petitioner failed admit on direct examination that she worked as a waitress prior to, during and subsequent to her alleged work injury and, in fact, that she had worked not one, but four different jobs subsequent to her alleged injury of November 9, 2018, and that she was an avid bowler who participated in and placed 5th in the Women's Masters Bowling Tournament in January of 2021. The Arbitrator finds it difficult to believe that the Petitioner was capable of all of the aforementioned activities while suffering from CRPS and pain at a scale of 8 out of 10. Based upon the totality of the evidence, the Arbitrator finds that the Petitioner failed to prove that her condition of ill being subsequent to April 18, 2019 was causally related to her injury of November 9, 2018. In so finding, the Arbitrator finds the Petitioner's testimony relative to his mechanism of injury to be both incredible and false and she relies upon the credible IME opinions of Dr. Noren.

In examining the entire record, the Arbitrator finds that the Petitioner failed to meet her burned of proving that her condition and treatment post April of 2019 were related in any way to her alleged injury of November 9, 2018. The Arbitrator bases that conclusion on the Petitioner's delay in reporting any shoulder pain or injury, as well as her inconsistencies in her reported mechanism of injury, the histories provided to her treating physicians and, finally, based upon Dr. Van's and Dr. Noren's examination findings and opinions.
The Arbitrator finds that that, at most, the Petitioner sustained a left wrist/forearm strain/sprain that had resolved by April 18, 2019. As such, the Arbitrator finds no causal connection between the Petitioner's condition of ill being subsequent to April 18, 2019 and her alleged injury of November 9, 2018.

(J) MEDICAL BILLS
(K) PROSPECTIVE MEDICAL CARE
(L) TTD BENEFITS
(N) WHETHER THE RESPONDENT IS DUE ANY CREDIT

The Arbitrator found that an accidental injury did occur but found no causal connection between the Petitioner's injury and her medical condition or need for treatment after April 18, 2019. Accordingly, the Arbitrator denies any and all medical expenses incurred by the Petitioner after April 18, 2019 and, also, denies and claimed TTD benefits.

The Respondent will receive a credit for all medical bills paid by the group carrier under Section 8(j) of the Act as stipulated to at the time of trial (i.e. $9,634.88). Additionally, Respondent will be given a credit for medical paid (i.e. $20,388.84) and for non-occupational disability benefits paid (i.e. $4,148.57). (RX 3) As the Arbitrator finds no causal connection between the Petitioner's injury and her treatment post April 18, 2019, all medical care post said date is denied, including prospective medical care.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC007679
Case Name	PEREZ, ROBERTO A v. PRESENCE CARE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0136
Number of Pages of Decision	45
Decision Issued By	Christopher Harris, Commissioner, Christopher Harris, Commissioner

Petitioner Attorney	Frank Kress
Respondent Attorney	Pankhuri Parti

DATE FILED: 4/12/2022

/s/Christopher Harris, Commissioner

Signature

DISSENT

/s/Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERTO A. PEREZ,

Petitioner,

vs. NO: 18 WC 7679

PRESENCE CARE,

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 causal connection, medical expenses, temporary total disability (TTD) benefits, permanent partial disability (PPD), maintenance benefits, and vocational rehabilitation, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission modifies, in part, vacates, in part, and affirms, in part, the Decision of the Arbitrator. For the reasons stated below, the Commission finds that the Petitioner established that his low back and his left knee conditions are causally related to the work-related accident of March 1, 2018. As a result, the Commission awards Petitioner outstanding medical expenses related to the low back and left knee, and TTD benefits from March 7, 2018 through March 28, 2021, the date of the arbitration hearing. The Commission further finds that the Petitioner is entitled to a vocational assessment pursuant to Section 8(a) of the Act. Accordingly, the Commission vacates

the PPD awards and vacates the Arbitrator's denial of maintenance and awards TTD in lieu thereof as follows.

Briefly, the Petitioner sustained an undisputed injury to his low back and left knee on March 1, 2018. The Petitioner was subsequently placed at maximum medical improvement (MMI) and returned to full-duty work on January 14, 2019 with respect to his left knee. Petitioner testified that he did not return to work as he still had restrictions for his low back. He was then terminated. Shortly thereafter the Petitioner had a recurrence of symptoms in his left knee and had continued low back pain. Because of this, Petitioner resumed treatment and ultimately underwent a functional capacity examination (FCE). Petitioner then received permanent restrictions that precluded him from returning to his pre-injury occupation.

The essence of Respondent's argument, with respect to the low back, is that Petitioner had a pre-existing condition that required him to undergo an MRI of the low back in 2007 and that Dr. Scott Glaser did not have a full picture of Petitioner's injury and treatment at the time he formulated his opinion. Because of this, the Respondent argues that the Arbitrator correctly adopted the opinions of Dr. Thomas Gleason that Petitioner sustained a temporary exacerbation of his low back and was at MMI two to three months after the accident. With respect to the left knee injury, the Respondent argues that the Petitioner did not return to work following his full-duty release to work and was not working when he developed the left knee pain. Therefore, his left knee pain beginning February 14, 2019 is not related to his employment.

The Commission is not persuaded by the Respondent's arguments. It is well-established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). Further, a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury.'" *Shafer*, 2011 IL App (4th) 100505, ¶ 39 (quoting *International Harvester*, 93 Ill. 2d at 63-64).

With respect to the low back, the Petitioner underwent an MRI of his low back in 2007. The Petitioner, however, testified that the doctor informed him that the MRI was fine. There is no evidence that the Petitioner's low back condition was symptomatic in the 10 years between the 2007 MRI and the March 1, 2018 accident and no medical records were offered showing that the Petitioner underwent any medical treatment during this 10-year period. There is also no evidence demonstrating that Petitioner's was limited, in any way, from performing his job duties prior to the accident. It was not until after the accident that the Petitioner began to undergo medical treatment to the low back.

The Commission finds the opinion of Dr. Glaser more persuasive than Dr. Gleason's opinion. Dr. Glaser's opinion that Petitioner's low back condition is causally related to the accident is supported by the facts and the law. While Petitioner may have had a pre-existing back issue, it was asymptomatic in the years before the accident and he was capable of working without

restrictions. Petitioner sustained a work-related accident that brought about his symptoms and necessitated treatment. The credible evidence demonstrates that his condition has not subsided or returned to its baseline. The Commission, therefore, finds that the Petitioner established causal connection between his low back condition and the work-related accident.

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

The Petitioner was released to full-duty work with respect to his left knee on January 14, 2019. At that time, he had full range of motion of the left leg. While he did not return to work, as Respondent did not accommodate his low back restrictions and instead terminated him, his knee symptoms returned a few weeks later in February 2019. Dr. Gleason, Respondent's Section 12 examiner, opined that the condition was not causally related as Petitioner had no symptoms at the time of his release and was not working when the symptoms returned. He also was of the opinion that the conditions were different. Dr. Ronald Silver, however, related the condition to the work accident. Dr. Silver opined that the current condition would not have happened but for the original accident and that it is very common for individuals to experience some improvement after surgery followed by a recurrence of symptoms.

The Commission finds Dr. Silver's opinion more persuasive than Dr. Gleason's opinion. Here, there is no evidence that Petitioner's left knee condition is related to anything but the original accident. There is no evidence of a pre-existing condition to the left knee and there is no evidence that he sustained a new injury. Petitioner sustained an undisputed work accident resulting in a meniscus tear, had delayed treatment, underwent surgery, was released back to work, and had an increase in knee symptoms shortly thereafter. This evidence supports Dr. Silver's opinion that the symptoms will essentially wax and wane and that his condition is just a continuation of those symptoms from his work injury. Further, Dr. Silver noted that Petitioner still had some discomfort when he placed him at MMI in January 2019. Dr. Silver noted there was no reinjury, just a

recurrence of symptoms. As there is no evidence of an intervening injury, the Commission finds that Petitioner's left knee condition continued to be causally related to the work-related injury.

The parties agree that TTD benefits were paid from March 7, 2018 through October 22, 2019. The Commission further finds that the Petitioner is entitled to TTD benefits from March 7, 2018 through May 28, 2021, the date of the arbitration hearing based on the ongoing, unaccommodated permanent work restrictions and Petitioner's termination from Respondent's employ. In order to prove his entitlement to TTD benefits, a claimant must establish not only that he did not work, but that he was unable to work. *Sharwarko v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 131733WC, ¶ 49, 390 Ill. Dec. 293, 28 N.E.3d 946. An employee is temporarily totally disabled from the time that an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118, 561 N.E.2d 623, 149 Ill. Dec. 253 (1990). Petitioner's entitlement to TTD for the foregoing period is based on Petitioner's inability to return to work for Respondent, Respondent's failure to accommodate the restrictions, and the Commission's findings on the need for a vocational assessment as rendered herein.

Following the valid FCE placing him in the light to medium demand level, Petitioner received permanent restrictions. Those restrictions preclude Petitioner from returning to his pre-injury occupation and Respondent has not accommodated the restrictions. As Petitioner established causal connection for his conditions of ill-being in his low back and left knee and further established that the restrictions are related to the work accident, the Commission finds that Petitioner is entitled to a vocational assessment to determine whether vocational rehabilitation is appropriate.

The Commission further finds that medical expenses related to the low back and left knee are reasonable and related to the work-related accident. As stated above, the Commission finds the opinions from Dr. Silver and Dr. Glaser more persuasive than Dr. Gleason's opinion. Both Drs. Silver and Glaser testified that the treatment provided to the Petitioner was reasonable and necessary. Therefore, the Commission finds that Petitioner is entitled to all outstanding medical expenses related to the low back and left knee.

Finally, the Commission vacates the PPD awards as Petitioner has been awarded a vocational assessment to determine the necessity of vocational rehabilitation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2021, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $410.01 per week for a period of 168-3/7 weeks, March 7, 2018 through May 28, 2021, 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. Respondent is entitled to a credit of $18,217.71 for TTD benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $88,584.97 for outstanding medical expenses under §8(a) of the Act and subject to the medical fee schedule. The Respondent is entitled to a credit of $150,991.67 for medical benefits that have been previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of 12.5% loss of use of the left leg and the award of 3% person-as-a-whole is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Petitioner is entitled to a vocational assessment to determine the necessity of vocational rehabilitation pursuant to Section 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.

April 12, 2022

/s/*Marc Parker*
Marc Parker

CAH/tdm
O: 3/17/22
052

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

DISSENT

I respectfully dissent from the Decision of the Majority and would affirm the Decision of the Arbitrator. Like the Arbitrator, I do not believe that the record supports causation after Petitioner was placed at MMI on January 14, 2019. The Petitioner sustained an injury to his left knee and low back and he received appropriate treatment through January 14, 2019. However, after being placed at MMI, I note that there are several inconsistencies in the record that negatively impact Petitioner's credibility. Therefore, I would affirm and adopt the Arbitrator's Decision in its entirety.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC007679
Case Name	PEREZ, ROBERTO A v. PRESENCE CARE
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Corrected Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	38
Decision Issued By	Steven Fruth, Arbitrator

Petitioner Attorney	Frank Kress
Respondent Attorney	Pankhuri Parti

DATE FILED: 10/13/2021

THE INTEREST RATE FOR THE WEEK OF OCTOBER 13, 2021 0.05%

/s/Steven Fruth, Arbitrator

Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
***Corrected* ARBITRATION DECISION**
19(b)

ROBERTO A. PEREZ, Case # **18 WC 7679**
Employee/Petitioner

v. Consolidated cases:

PRESENCE CARE,
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 **March 28, 2021**. After reviewing all 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 vocational services?
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: What is the nature and extent of the injury?**

FINDINGS

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

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

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

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

Petitioner's claimed current conditions of ill-being ***are not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**7,381.80**; the average weekly wage was $**615.15**.

On the date of accident, Petitioner was **63** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$18,217.71** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of **$18,217.71**.

Respondent is entitled to a credit of **$150,991.67** under §8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, adjusted in accord with the medical fee schedule, until June 11, 2018 for the lower back injury and until January 10, 2019 for the left knee injury, as provided in §§8(a) and 8.2 of the Act. Respondent shall be given a credit of $150,991.67 for medical benefits that have been paid.

Respondent is not liable for the claimed bills in the amount of $42,319.44 from Rx Solutions or in the amount of $13,231.72 from Persistent Rx.

Temporary Total Disability

Petitioner proved that he is entitled to Total Temporary Disability benefits from March 3, 2018 through January 10, 2019, 45 & 1/7 weeks, at a rate of $410.01/week. Respondent shall be given a credit of $18,217.71 for TTD benefits that have been paid. Petitioner reached MMI on January 10, 2019 and therefore failed to prove entitlement to additional TTD benefits.

Maintenance

No maintenance benefits are owed to Petitioner due to the evidence established that Petitioner had reached MMI and was capable of full duty work

Vocational Rehabilitation

Petitioner failed to prove that he is entitled to vocational rehabilitation because the evidence established that he had reached MMI by January 10, 2019 and was capable of full duty work.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $**369.09**/week for **15** weeks, because the lower back injuries sustained caused a **3%** loss of a person-as-a-whole, as provided in §8(d)2 of the Act.

Respondent shall also pay Petitioner permanent partial disability benefits of $**369.09**/week for **26.875** weeks, because the left knee injuries sustained caused a **12.5%** loss of left leg, as provided in §8(e) of the Act.

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

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

_____ **OCTOBER 13, 2021**

Signature of Arbitrator

Roberto Perez v. Presence Care
18 WC 7679

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 vocational rehabilitation?; ***L:*** What temporary benefits are in dispute? TTD/Maintenance; ***O:*** What is the nature and extent of the injury?

Disputed medical bills included: Rx Solutions, $42,319.44; Elmwood Park Same Day Surgery, $1,745.09; Elmwood Park Same Day Surgery (Dr. Glaser charges), $24,768.72; Lincolnwood Rehabilitation, $5,265.00; Athletico, $1,255.00; and Persistent RX, $13,231.72.

The parties also agreed and stipulated that if the Arbitrator finds that Petitioner fails to prove that he is entitled to vocational rehabilitation and maintenance then that the Arbitrator make a determination of permanency.

STATEMENT OF FACTS

Petitioner Roberto Perez testified that he was hired as a floor finisher for Respondent Presence Care at Resurrection Medical Center in January 2018. He had been working in that capacity up to March 1, 2018. Petitioner testified that as a floor finisher he was required to maneuver and manipulate a polishing machine that weighed 150 pounds. He would have to lift the polishing machine onto a cart which also contained the chemicals needed to polish floors. The fully loaded cart weighed approximately 350 pounds. Petitioner also testified that he was also expected to clean patient rooms.

Petitioner testified that he was required to take the loaded cart to each room that needed to be cleaned. He would then take all hospital equipment out of the room. Prior to polishing the floors, he would mop the floor and take off the old wax. He would use the polishing machine to put on new wax. He explained that the polishing machine was very powerful and required two hands to control. Upon completing the polishing of the floor, he had to load everything back into the cart and replace all items back in the hospital. He then would return all his equipment back to storage. He would clean the polishing machine, throw out any garbage, empty buckets, and then proceed back to the office to report.

Petitioner testified that on occasion he was assigned to vacuum stairwells. He would use a vacuum that strapped on his back like a backpack. He explained that when he cleaned stairwells, he began with the sixth floor of the hospital and proceed down.

On March 1, 2018 Petitioner was working for Respondent. He was directed to vacuum dirty stairs and clean the stairwell that had a lot of spider webs. Petitioner testified that he proceeded down the stairs while vacuuming with the backpack vacuum. As he descended the stairs, his feet became entangled in the hose to the vacuum cleaner, causing him to lose his balance and fall. He missed one, two, or three steps and landed hard on his left foot, twisting his left knee. He felt a lot of pain in his left knee and in his low back.

Petitioner was transported to Respondent's Emergency Department that same day (PX #5). He reported that he tripped on a cord walking down stairs, missed a step, and landed on his left foot. He complained of left knee pain that radiated to his left hip and low back pain. He was unable to bear weight on his left leg. He complained of 9/10 pain. On examination there was tenderness and swelling in the left knee. X-rays of the knee demonstrated mild degenerative changes of the posterior cortex of the patella. Petitioner was diagnosed with "acute pain of left knee" and discharged with ibuprofen, an Ace wrap for the knee, and instructions to follow up with Family Medicine if his symptoms worsened. There were no notes regarding work status.

Petitioner consulted Dr. Aleksandr Goldvekht of Advanced Physical Medicine for follow-up on March 3, 2018 (PX #3 & RX #1). Petitioner gave a history of walking down stairs and falling when he missed a step. He was treated in the ER where X-rays and medications were given. Petitioner presented with pain in his lower back and left knee. Bending, lifting, carrying, pushing, and pulling aggravated his pain. He reported that he could not sit for long periods due to his discomfort. He also reported a history of hypertension.

On examination Petitioner's antalgic gait was noted. Range of motion of the lumbar spine was decreased. He had tender trigger points and hypertonicity over the lower paraspinal muscles. Dr. Goldvekht noted marked crepitus on flexion and extension of the left knee as well as effusion. There was tenderness at the medial and lateral aspects of the infero-patellar region. McMurray and Aptly tests were positive; Kemp's was positive on the left. Dr. Goldvekht noted decreased sensation to light touch in the left leg/ankle/foot. Left leg strength was also diminished. Straight-leg raise was positive on the left at 30°. Patrick's test on the left was positive also.

Dr. Goldvekht diagnosed "lumbar disc" with left lower extremity radiculitis and left knee injury. He prescribed Mobic, Protonix, Flexeril, and Terocin pain patches. Dr. Goldvekht stated the Terocin pain patches were of "to allow the patient to avoid additive [*sic*] quality of pain medication." It is presumed that the doctor meant "addictive quality

of pain medication," although he did not prescribe opiates or other narcotics. He also ordered urine toxicology, normally prescribed to monitor use/abuse of prescribed opiates or other narcotics. Dr. Goldvekht also prescribed a TENS unit and a lumbar brace as well as a course of physical therapy and a left knee MRI. Petitioner was kept off work.

The March 8, 2018 MRI (PX #1 & PX #3) noted subtle blunting of the apical free edge of the mid body, probably a small tear, of the lateral meniscus. The medial meniscus as well as the collateral and cruciate ligaments were intact. There was also small joint effusion.

Petitioner returned to Dr. Goldvekht on March 19 for review of the MRI (PX #3). Petitioner presented with the same complaints and limitations as before. He reported his pain at 7/10. The findings on clinical examination and the diagnoses were unchanged. The diagnoses were unchanged. There were no changes in the treatment plan: medication remained the same and physical therapy was to continue. Dr. Goldvekht ordered a lumbar MRI and referred Petitioner to an orthopedic surgeon for evaluation of the left knee.

Petitioner began physical therapy at Athletico for his left knee and low back on March 9, 2018 (PX #6). Presenting complaints were low back pain aggravated with prolonged sitting, getting in and out of bed, and prolonged walking. He reported numbness and tingling down to the left knee. Pain was aggravated by flexion and bending down to pick up objects off the floor. He also gave a history of low back pain "10 years ago." He reported 8–9/10 pain and taking ibuprofen 2-3 a day. Assessment of lumbar motion was noted at 25% of normal, except for 0% side bending. Left knee range of motion was diminished. Left knee strength was 4-/5.

There were two Athletico discharge notes, dated April 2 and April 16, 2018. Both documented Petitioner attending 6 appointments but cancelling 3. It was noted that he was transferring therapy to a clinic closer to his home.

Petitioner consulted orthopedic surgeon Dr. Ronald Silver March 22, 2018 for his left knee (PX #2). Dr. Silver noted that Petitioner had injured other parts of the body but that his focus was the knee. Petitioner gave a history of falling down 3 to 4 steps at work and twisting and jamming his left knee. Petitioner was in physical therapy. He complained of swelling, clicking, popping, and giving way.

Examination revealed lateral joint line tenderness and a positive McMurray's. Flexion beyond 90° was painful. The patellofemoral joint was benign to crepitus and apprehension. Dr. Silver noted the MRI demonstrated a lateral meniscus tear with joint effusion.

Dr. Silver opined that the torn meniscus was due to Petitioner's work injury and that arthroscopic surgery was required. He recommended continued physical therapy.

Dr. Silver discontinued Hydrocodone utilizing topical Lidocaine and Terocin patches to supplement Ultram, so as to diminish the possibility of opioid dependency. Protonix was also added for GERD symptoms. Dr. Silver noted that Petitioner was temporarily disabled.

Reports of toxicology screening ordered by Dr. Silver were included in PX #2, although Dr. Silver did not document ordering this screening. The March 22, 2018 survey revealed no evidence of prescribed cyclobenzaprine, Tramadol, or o-Desmethyltramadol. The surveys on May 3 and June 14, 2018 showed evidence of those drugs, which was consistent with their prescriptions. The August 2, 2018 survey revealed no evidence of prescribed cyclobenzaprine, Tramadol, or o-Desmethyltramadol. None of the surveys revealed evidence of hydrocodone, which other records indicate had been prescribed.

The March 23, 2018 lumbar MRI, ordered by Dr. Goldvekht, demonstrated a 3-4 mm broad-based protrusion/herniation at L5-S1 indenting the thecal sac with mild bilateral neuroforaminal narrowing and 2-3 mm posterior bulging at L3-4 and L4-5 indenting the thecal sac with mild bilateral neuroforaminal narrowing.

Petitioner testified that on April 6, 2018 he started therapy at Lincolnwood Rehabilitation Center ("Lincolnwood") because he felt he was not getting enough attention at Athletico. He said Athletico was attending to too many other people. The clinical notes are handwritten and difficult to decipher. On initial assessment knee flexion was 80° with pain; extension was 22+° with pain. Knee strength was 3/5. There are no notes relating to pain or assessment of the low back. Petitioner's therapy continued through July 6, 2018, at which time some improvement in motion, strength, and pain was noted but without attaining stated goals.

Petitioner returned to Dr. Goldvekht on April 16, 2018. Petitioner reported no change since the previous visit. The findings on clinical exam were unchanged, as were the diagnoses and treatment. Dr. Goldvekht referred Petitioner to interventional pain management for his lumbar spine.

Board-certified orthopedic surgeon Dr. Brian Neal performed a §12 IME of Petitioner on April 26, 2018 (PX #1, PX #2, & PX #3). Prior to the clinical examination Dr. Neal reviewed Petitioner's records from Resurrection Medical Center ("RMC") Emergency Department, Dr. Aleksandr Goldvekht of Advanced Physical Medicine, and Dr. Ronald Silver.

Dr. Neal noted the RMC records documented Petitioner's report that his leg got caught on a cord and that he misjudged his step down and fell. He reported feeling a pop and pain in his knee. On examination the left knee was mildly tender around the quadriceps and the medial joint line. Range of motion was normal but painful.

Dr. Neal noted that Petitioner gave a similar history of injury to Dr. Goldvekht who diagnosed "left knee injury." Dr. Goldvekht prescribed medication, including Mobic, Protonix, Flexeril, Terocin patches, and urine toxicology testing. He also ordered a TENS unit, lumbar bracing, physical therapy, a left knee MRI, and straight cane usage. Dr. Goldvekht placed Petitioner on "total temporary disability." Dr. Goldvekht noted the left knee MRI demonstrated a probable small tear of the lateral meniscus and joint effusion.

Dr. Neal noted that Petitioner saw Dr. Ronald Silver for an orthopedic evaluation of the left knee. On examination Dr. Silver noted lateral joint line tenderness, a positive McMurray, painful motion to 90° of flexion, and stable ligaments. Dr. Silver diagnosed a torn lateral meniscus due to the reported work accident and that arthroscopy was necessary.

On examination by Dr. Neal Petitioner reported that he had not been working as a floor finisher for Resurrection Hospital since March 1, 2018. Petitioner described his job activities. He gave a history of 20 years of self-employed maintenance work prior to his employment with Resurrection. Petitioner denied any injury prior to his March 1, 2018 work accident.

Petitioner reported that his current injuries were with his left knee and his back. He also complained of right knee pain, which had begun about a week before the IME. Petitioner described his fall down 3 or 4 stairs at work on March 1, 2018 and landing on his left foot, and then falling to the ground onto his left knee. Petitioner reviewed his Emergency Department care and his consultations with Drs. Goldvekht and Silver. He had not seen his primary physician, Dr. Ninan, since his accident. He denied that he had seen Dr. Ninan for knee or back problems before his accident. He was currently taking Meloxicam, Tramadol, Pantoprazole, Cyclobenzaprine, and Terocin Patch.

At the IME Petitioner complained of a lot of pain and that his balance was gone. He stated he could not stand by himself and used a cane. He stated he used the cane for both his back and his left knee symptoms. Petitioner described diffuse shooting pain about the left knee but also complained that both legs were weak. His left knee pain was anterior and lateral and extended laterally along the leg "almost to my ankle." He complained that his knee would lock and catch. He felt like his knee will buckle or give way. He reported that he uses a brace provided by Dr. Silver but was not wearing it at the time of the IME. He stated he left the brace in his car.

Petitioner reported that he could perform all of his regular job duties before his accident. He stated that before his accident he had no left knee pain, could walk fast, and was "perfect." On examination Dr. Neal observed Petitioner walked slowly with an antalgic gait, using his cane in his left hand. Petitioner had apparent back pain and occasionally touched his lower back with his right hand. Petitioner could not fully extend his left knee, lacking 10° of extension. The left knee rested at 75° of flexion when resting

over the side of the examination table. There was subjectively significant tenderness to palpation on all four quadrants of the leg. Dr. Neal noted subjective pain to light rubbing over the patella and tibial tubercle. Very light touch to the posteromedial and posterolateral hamstrings elicited very tender sensations. There was tenderness to light touch of the soft tissues of the distal third of the thigh in all four quadrants. There was pain to light touch over the patella, tibial tubercle, mid posterior calf, and proximal anterior thigh. The medial and lateral joint lines were exquisitely painful to light touch. Petitioner demonstrated 90° of active flexion. Left knee collateral medial and lateral stability was attempted but was painful.

Dr. Neal reviewed the left knee MRI from March 8, 2018. He noted the anterior and posterior cruciate ligaments were intact. He noted that the medial lateral meniscus [*sic*] (presumably the medial and lateral menisci) "are fairly normal" but with some edema about the periphery.

Dr. Neal found Petitioner's symptoms medically unexplainable and without organic basis. He noted Petitioner's subjective knee pain was excessive and disproportional to objective findings. Dr. Neal found it impossible for all complaints to have originated from an intra-articular or a particular knee problem. He also noted it was impossible for Petitioner's complaints to originate from a lumbar spine condition, if he had one. Dr. Neal opined that there were significant underlying biopsychosocial psychogenic undercurrents and symptom magnification.

Based on his examination and review of the MRI Dr. Neal did not recommend surgery at that time. He did recommend an intra-articular injection with or without a corticosteroid. However, Dr. Neal also noted that if Petitioner continued to demonstrate an inability to fully extend the left knee then a diagnostic arthroscopy would be indicated. He added his opinion that based on non-orthopedic cofounders, which he could not identify, Petitioner had a poor prognosis.

Dr. Neal also opined that even though Petitioner had a perfectly asymptomatic history prior to a fall he could not conclude that Petitioner's left knee condition was related to a work accident because of unexplainable elements and the lack of any medical records prior to March 1, 2018. He noted that records prior to March 1, 2018 were readily available.

Dr. Neal stated Petitioner could return to work but would not be able to work without restrictions. Petitioner would have to work at a slower than average cadence and would be restricted from working on his knees or climbing ladders. Dr. Neal would limit Petitioner to lifting no more than 30 pounds.

Dr. Neal's opinions were without regard to Petitioner's back condition, for which he expressed no opinions.

Petitioner followed up with Dr. Silver on May 3, 2018. Dr. Silver noted that he was awaiting approval of the recommended surgery. He added that Petitioner would have a permanent disability without surgery. Petitioner's clinical presentation was unchanged. Dr. Silver's medication regimen and treatment plan were also unchanged.

Petitioner testified he first saw Dr. Glaser on May 21, 2018 (PX #3). He presented with complaints of 8/10 bilateral lower back pain radiating into both hips, buttocks, and thighs with sitting and standings. Petitioner also complained of constant numbness. He reported that his pain is 10/10 at worst. Petitioner also reported his current medications included Terocin patch, cyclobenzaprine, pantoprazole, meloxicam, and tramadol. On examination the lower back was tender. Lumbar range of motion was limited. Straight-leg raise on the right and the left elicited calf pain. Sensory response was normal in both legs. Dr. Glaser diagnosed lumbar radiculopathy and facet syndrome and recommended epidural steroid injections ("ESI") at L4-5 and L5-S1.

Petitioner returned to Dr. Goldvekht June 11, 2018. Complaints and clinical exam findings were unchanged. The diagnoses and treatment plan remained unchanged. Dr. Goldvekht continued to keep Petitioner off work.

On June 14, 2018 Dr. Silver wrote a response to Dr. Neal's IME recommendation of a left knee cortisone injection and a clinical note (PX #2). Dr. Silver noted that a cortisone injection was not the appropriate treatment for a torn lateral meniscus. Even so, Dr. Silver did administer the injection. He noted that Petitioner still had lateral joint line tenderness. Petitioner had painful knee flexion beyond 90° and had great difficulty extending the knee. There was mild effusion and a positive McMurray sign.

Dr. Silver ordered continued physical therapy. He noted Petitioner had been weaned off Hydrocodone using topical Lidocaine and Terocin patches to supplement Ultram. Diclofenac was added to Mobic to reduce inflammation. He also noted that Protonix had reduced GERD symptoms. Dr. Silver continued with his opinion that Petitioner was temporarily disabled.

Petitioner testified that on June 14, 2018 Dr. Silver was still recommending surgery.

Petitioner testified to receiving the epidural steroid injection on the lumbar spine on June 19, 2018 by Dr. Glaser (PX #3). Petitioner testified that he followed up with Dr. Glaser on July 10, 2018. The clinical note for that visit is signed by Alexa Lerch, whose credentials are not noted (PX #3). Petitioner reported that he had 25% pain relief but that symptoms had returned to 8/10 pain. On examination lumbar motion was still diminished. Petitioner testified that during this visit Dr. Glaser recommended another ESI. Only Ms. Lerch signed the recommendation for another ESI.

Petitioner testified that he saw his primary physician on July 12, 2018 for pre-operative clearance for the scheduled knee surgery. He admitted to having an MRI of the lumbar spine done back in 2007 because of back pain at the time but that he did not receive any additional treatment apart from the MRI.

Petitioner's primary physician, Dr. Reji Ninan, performed a pre-operative examination (PX #3). Dr. Ninan documented Petitioner's history of falling down 3 to 4 steps, twisting his left knee, and hurting his low back. Dr. Ninan noted Petitioner's care with Dr. Silver and a diagnosis of a torn left knee meniscus and that Petitioner had had a cortisone injection. Dr. Ninan also documented Petitioner's care with Dr. Glaser and an MRI showing a 3-4 mm posterior disc protrusion/herniation at L5-S1 along with 2 mm bulges at L3–4 and L4–5. Also, Dr. Glaser's transforaminal ESIs June 19, 2018 at L4-5 and L5-S1 were noted.

Dr. Ninan also noted Petitioner's history of a lumbar MRI in 2007 that showed multilateral degenerative disc disease, an annular tear at L4–5, and mild to moderate neural foraminal stenosis at L5–S1 due to left hypertrophy.

Board-certified orthopedic surgeon Dr. Thomas Gleason performed a §12 IME of Petitioner's lower back on July 24, 2018 (PX #1 & EX #2 to RX #7). In addition to performing a clinical examination, Dr. Gleason reviewed Petitioner's medical records from Drs. Aleksandr Goldvekht and Ronald Silver. Dr. Gleason also reviewed the May 1, 2018 IME report of Dr. Bryan Neal, Petitioner's lumbar X-rays from the July 24 exam, and the lumbar MRI from March 23, 2018.

Petitioner gave a history of falling down 3 to 4 stairs on March 1, 2018 while at work. He landed on his right foot and twisted his left knee and back. He had immediate knee pain and some lower back pain. Following treatment in the emergency room he followed up with "Dr. Alexander" for his left knee and low back. MRIs and medications were prescribed, and physical therapy was recommended for both the left knee and low back. However, therapy for the left knee only was approved. Petitioner was then referred to Dr. Glaser, a pain specialist, for low back pain. He had an epidural injection which provided little relief. Dr. Glaser prescribed physical therapy which was still pending approval. Another injection was tentatively scheduled for August 6, 2018. Left knee surgery was scheduled for July 27 with Dr. Silver.

Petitioner reported that he had had no complaints or injuries to his lower back or left knee prior to March 1, 2018. He also reported that he had not worked since March 1, stating his job entailed lifting between 50 to 100 pounds. He was currently taking Mobic and cyclobenzaprine.

On examination Petitioner presented using a cane. He stated that he never goes without using it. Dr. Gleason noted Petitioner stood and walked with a non-antalgic gait but intermittently put his right hand on his lower back while using a cane in his left hand.

He stood with primary weight-bearing on the right leg. He was able to stand on his toes bilaterally but had some difficulty standing on his left heel. There was normal curvature of the spine. Petitioner had diffuse tenderness on palpation over the lumbar spine as well as the left lower paralumbar areas. There was no spasm, tenseness, or asymmetry.

Petitioner was able to bend forward to one handbreadth below the knees and was able to extend to 5°. Pelvic compression and pelvic distraction tests were negative but painful. Left knee extension on the left was less than on the right. Petitioner complained of groin pain with gentle rotation of both lower extremities. He resisted straight leg raise bilaterally at 15°. Pinprick sensation over the L4–L5–S1 distributions were intact but was diffusely limited over the right leg. There was generalized back pain with the Fabere test. Muscle strength in the hips, knees, and ankles was normal. Lumbar spine X-rays demonstrated diffuse moderate degenerative disc disease at L3–L4–L5–S1. The MRI demonstrated moderate diffuse degenerative disc disease with protrusions at L3–L4–L5 indenting the thecal sac as well as mild central stenosis and foraminal narrowing.

Dr. Gleason adopted the findings of the diagnostic studies, including the lumbar MRI of March 23, 2018, and further noted no positive objective findings with respect to the low back. He noted that subjective complaints outweighed objective findings, adding that subjective complaints could not be explained with known pathoanatomical entity. Dr. Gleason added that Dr. Neal had found Petitioner's presentation "medically unexplainable." He added that the findings were inconsistent and even contradictory, which is suggested magnification or exaggeration.

Dr. Gleason opined that Petitioner sustained a soft tissue strain or temporary exacerbation of a pre-existing condition in the low back which he expected to have improved, healed, and resolved within a relatively brief period of time. He further opined that the work incident did not aggravate a pre-existing condition although it may have temporarily exacerbated that pre-existing condition.

Dr. Gleason also opined that Petitioner's medical care through June 11, 2018 was reasonable and necessary but noted that care following that date was excessive and unnecessary and was not related to the reported work injury. He added that Petitioner required no further medical care and with regard to the lower back Petitioner could return to full duty work without restrictions, adding that Petitioner had attained MMI with respect to his lower back.

Dr. Silver performed an arthroscopic partial lateral meniscectomy, tricompartmental synovectomy, lysis of adhesions, and debridement on Petitioner's left knee on July 27, 2018 (PX #2). Petitioner followed up with Dr. Silver on August 2 when he had 80° of flexion with full extension. He began physical therapy on August 17, 2018 at Lincolnwood Rehabilitation Center ("Lincolnwood").

Petitioner saw Dr. Goldvehkt again on August 6, 2018. Petitioner reported no change with his left knee since his surgery. He also reported that there was no change after the interventional pain procedure. The findings on clinical exam were the same as all before. As before, the diagnoses and treatment were unchanged. Petitioner was advised to follow up with orthopedics and pain intervention. Petitioner was again kept off work.

Petitioner returned to Dr. Glaser on August 15, 2018 with 7/10 low back pain but reporting pain was 9/10 at its worst. Motion of the lumbar spine was limited by pain. Straight-leg on the right elicited buttock pain; straight-leg raise on the left elicited calf pain. Dr. Glaser noted that he would respond to the recent IME.

Petitioner testified that he had a second epidural steroid injection in the lumbar spine on August 21, 2018, which was the last injection performed. On that day Petitioner marked a body diagram noting bilateral posterior leg pain down to the feet. The record noted Petitioner was taking Enalapril (for hypertension) daily as well as Tramadol and Hydrocodone PRN. There is no operative report regarding the August 21 ESI in PX #3 but there are attendant pre- and post- operative, anesthesia, and billing records.

Dr. Glaser wrote an "IME response", which was apparently faxed September 8, 2018 (PX #3) in which he was highly critical of the "IME doctor from Illinois Bone and Joint." Dr. Glaser noted, "[A]s with most IME physicians, he ascribes the pain to soft tissue strain and exacerbation of pre-existing condition. For this opinion to be correct, the patient would have fully recovered from the work injury which he did not obviously."

Dr. Glaser went on to note that medical literature, without citation, does not support and in fact contravened the IME opinions. Dr. Glaser noted that the hallmark of a strain is that symptoms are time-limited, which he noted was not the case with Petitioner's presentation. He noted that when symptoms persist there must be a more severe injury to joints and/or nerves. Dr. Glaser further noted the IME doctor's opinions were based on a "faulty premise." He went on, "[T]his is an example of sophistry, and the IME doctor should be ashamed. Is faulty and misleading IME is leading to the denial of appropriate care for a patient injured on the job."

Petitioner returned to Lincolnwood for post-operative therapy on August 17, 2018. Again, the clinical notes were handwritten and difficult to decipher. Post-operative therapy continued through November 30, 2018.

Petitioner saw Dr. Silver on September 13, 2018 when he had reduced swelling and 110° of flexion. Dr. Silver advanced Petitioner to sedentary work but continued physical therapy. Petitioner saw Dr. Glaser on October 17, 2018 with complaints unchanged since "09/05/2018" [*sic*]. Petitioner still had pain on lumbar motion. Dr. Glaser advised continued physical therapy.

Petitioner returned to Athletico for physical therapy for chronic low back pain with bilateral sciatica on October 24, 2018 on referral by Dr. Glaser (PX #6). He presented with 7/10 pain but reported his best pain rating was 4 and the worst was 10. Petitioner reported he had had an epidural for his low back pain one month before which helps the pain but did not alleviate all symptoms. Petitioner's assessment and therapy was limited to the low back. No complaints of left knee pain or assessment of left knee or therapy for the left knee were documented.

Petitioner was discharged from Athletico January 18, 2019, having kept 5 appointments and cancelling 13. It was noted that Petitioner went to another facility "per WC." Petitioner testified he made the switch because his therapist was sick, and he was not getting the treatment he needed at Athletico.

There were no changes when Petitioner returned to Dr. Goldvehkt on September 17, 2018. Petitioner reported no change from his second interventional pain procedure. There were no fundamental changes at Petitioner's last visit with Dr. Goldvehkt on October 29, 2018. He reported that he was awaiting approval for a third interventional pain procedure. Petitioner continued to complain of low back pain which radiated into his left leg and knee. As before, he complained that bending, lifting, carrying, pushing, and pulling aggravated his pain. He reported that he could not sit for long periods due to his discomfort. Dr. Goldvehkt to follow up with interventional pain management and to return to him as needed.

Petitioner returned to Dr. Glaser on November 28, 2018. The clinical note was incomplete. He reported no change in his back symptoms since the October 17 visit. Current medications include DDB Compound Cream, cyclobenzaprine, Mobic, Terocin Patch, pantoprazole, Meloxicam, and Tramadol. Petitioner testified he has not returned to Dr. Glaser. He testified that Dr. Glaser wanted to schedule more appointments, but they were not approved.

Petitioner testified he had 5 sessions of therapy at Athletico, the last of which was on November 2, 2018, and then he returned to Lincolnwood since his therapist was back. Petitioner testified his final session of therapy was on November 30, 2018 and then followed up with Dr. Silver on December 6, 2018. He was given restrictions of no squatting, kneeling, crawling, or climbing. Petitioner testified that on January 10, 2019 Dr. Silver released him to regular work as of January 14, 2019.

Petitioner testified he called his work to explain that Dr. Silver released him to return to work, but that Dr. Glaser still had restricted him from working. He testified that he was then fired from his employment.

Dr. Gleason performed a §12 IME of Petitioner's left knee on December 18, 2018 (PX #1 & EX #3 to RX #7). As before, in addition to the clinical examination Dr. Gleason reviewed Petitioner's medical records and imaging. He noted that Dr. Silver administered

a cortisone injection on June 14, 2018 and then performed a left knee arthroscopy on July 27, 2018.

Dr. Gleason took note of Dr. Scott Glaser's August 15, 2018 response to his previous IME.

Petitioner presented for the IME with complaints of improved left knee pain since his surgery. He complained of popping and the knee giving out. He also had numbness over the front of the kneecap down to the anterior upper quarter of the calf. On examination Petitioner could stand on heels and toes bilaterally. He could stand and walk with a non-antalgic gait without using a cane. He could bend forward to mid-calf and could extend to 10°. There were negative pelvic compression and pelvic distraction tests. Hip, knee, and ankle motions were equal bilaterally. There was no groin pain on gentle rotation of the lower extremities. Straight-leg raise was negative bilaterally. Sensation to pinprick was intact over L4-L5-S1 nerve root distributions. Hip, knee, and ankle strength were normal.

On further examination there was no effusion, warmth, or erythema in the left knee. There was moderate crepitus. There was no pain or instability on varus or valgus stress and no medial or lateral joint line tenderness. McMurray, Lachman, and anterior and posterior Drawer were all negative.

Dr. Gleason diagnosed a symptomatic tear of Petitioner's left lateral meniscus that was related to his work accident on March 1, 2018, noting the described mechanism of the fall was competent cause a meniscus tear. Dr. Gleason opined that the treatment, testing, therapy, and medications relating to the left knee have "for the most part" been reasonable, necessary, and related to the March 1 work accident, including the arthroscopic surgery.

Dr. Gleason further opined that Petitioner required no additional institutionalized/formalized medical treatment. A home exercise program as well as weight loss was encouraged. He acknowledged that over-the-counter medication might be beneficial. Dr. Gleason also opined that Petitioner had no current physical limitations or work restrictions relating to the March 1 accident, adding that Petitioner was at MMI by November 30, 2018.

Petitioner testified he called his work to explain Dr. Silver released him to return to work, but that Dr. Glaser still had restricted him from working. He testified that he was then fired from his employment.

Petitioner testified he returned to see Dr. Silver on February 14, 2019 and was referred for a new left knee MRI. On February 14 Dr. Silver noted Petitioner complained of a severe recurrence of left knee pain to the point where he could barely walk (PX #2). On examination there was peripatellar tenderness and mild effusion. There were no

definite meniscal clicks. Motion was painful beyond 90° of flexion. Plain X-rays of the left knee were within normal limits. Dr. Silver noted Petitioner was temporarily disabled and ordered the MRI. He further prescribed topical pain medication to diminish the use of opioid medication, as well as Protonix for GERD symptoms. There are no notes that Dr. Silver had prescribed opioid medication or that Petitioner was taking opioid medication or that Petitioner was at risk of abusing opioids or that Petitioner had complained of GERD symptoms

The February 26, 2019 MRI demonstrated intact ACL, PCL, MCL, and LCL (PX #2). The lateral meniscus demonstrated subtle blunting of the apical free edge of the midbody, but it was difficult to differentiate whether it was a post meniscectomy change or a tear. There was joint effusion, but the medial meniscus was intact.

Dr. Gleason performed a §12 IME on Petitioner's left knee and low back on April 23, 2019 (EX #4 of RX #7). In addition to a clinical examination Dr. Gleason reviewed his prior reports and additional medical records.

Dr. Gleason noted that since the last examination petitioner had been seen Dr. Glaser. He had had to epidural injections with relief for only a week and a half. Authorization for a third epidural was pending approval. Petitioner also reported his continued care with Dr. Silver. Petitioner reported improvement over the outer aspect of his left knee but had pain around the kneecap and the front of the knee. An MRI of the left knee was performed February 26, 2019. Approval for medication and physical therapy for the knee was pending.

Dr. Gleason reviewed lumbar X-rays from April 23, 2019, which demonstrated a left convexity with moderate degenerative disc disease, especially at L3–L4–L5–S1, with associated disc space narrowing and spurring. He noted no obvious change from July 24, 2018 X-rays. Dr. Gleason again reviewed the lumbar MRI from March 23, 2018, which demonstrated moderate diffuse degenerative disc disease with associated disc space narrowing. There was bulging at L3–L4–L5 with small central protrusions indenting the sac with mild central spinal stenosis and foraminal narrowing. Standing X-rays of the left knee demonstrated lateral subluxation of the patella similar to findings on December 18, 2018. The left knee MRI from February 26, 2019 demonstrated blunting of the free edge of the mid body of the lateral meniscus, consistent with postoperative change involving partial meniscectomy on July 27, 2018. In addition, there was lateral subluxation of the patella with chondromalacia involving the lateral patellofemoral joint, as well as joint effusion.

On examination Dr. Gleason noted Petitioner's slow, somewhat stiff-legged gait with or without the use of his cane and grasping his lower back with his hand. Petitioner was able to stand on toes and heels bilaterally. There was some lower lumbar tenderness on palpation, otherwise no other spinal or paraspinal tenderness. There was no

paraspinal spasm, tenseness, or asymmetry. Petitioner was able to bend forward while grabbing his knees. He was able to extend to 10° but with groaning and buckling of his knees. Petitioner used his right leg to get up and down from the examination table. Bilateral hip motion was symmetric.

Dr. Gleason noted bilateral knee motion was equal and symmetric. However, he noted that bilaterally each knee demonstrated flexion at 90° and then later at 130°. Deep tendon reflexes were equal and symmetric. Sensation to pinprick over the L4–L5–S1 nerve root distributions was intact. Straight-leg raise and Fabere tests were negative bilaterally. Muscle strength at the hips, knees, ankles, and feet was normal.

Dr. Gleason noted moderate crepitation in both knees. There was no pain on varus or analogous stress of the knees. There was no medial or lateral joint line pain. There is no effusion, warmth, or erythema of the left knee. There was some medial retro-patellar pain but no lateral retro-patellar pain. Dr. Gleason noted a suggestion of the lateral subluxation of the left patella on flexion and extension as well as positive patellofemoral compression. McMurray, Lachman, and anterior and posterior drawer were negative bilaterally.

Dr. Gleason noted the postoperative presentation of Petitioner's left knee and diagnosed symptomatic chondromalacia of the left patella with patella malalignment. However, he also noted no positive objective findings on physical examination of the low back. His reviewed Petitioner's medical records. Dr. Gleason noted Dr. Silver's left knee arthroscopic partial lateral meniscectomy as well as a tricompartmental synovectomy, lysis of adhesions, and debridement. He also noted Dr. Glaser's bilateral transforaminal epidural steroid injections at L4–L5–S1. Dr. Gleason noted that Dr. Silver's findings of full range of motion and diminished atrophy of Petitioner's left knee on January 10,2019, at which time he released Petitioner to normal work activities.

Petitioner returned to Dr. Silver on February 14, 2019 complaining of severe recurrence of left knee pain, to the point where he could barely walk. Dr. Silver noted painful motion beyond 90° of flexion.

Dr. Gleason noted that Petitioner did not attribute the reemergence of knee symptoms to any specific event. On examination Dr. Gleason noted Petitioner's subjective knee complaints outweighed objective medical evidence. There were inconsistencies in gait, getting on and off the examination table, and in active motion. He reiterated his prior opinion that Petitioner was at MMI with respect to his left knee by December 18, 2018 and that Petitioner's current condition of chondromalacia was not related the March 1, 2018 work accident.

Dr. Gleason further opined that Petitioner's intermittent complains of low back pain are not related to his work accident. Petitioner's complaints were not supported by objective findings. Dr. Gleason expressed his disagreement with Dr. Glaser's July 24,

2018 reply letter. He stated that his opinions were supported by medical literature. He added that he knew of no Grade I evidence-based medical literature that supports giving a series of epidural injections in the absence of objective examination findings. Dr. Gleason reiterated that Petitioner was at MMI with respect to his lower back.

Dr. Gleason finally opined that Petitioner, being at MMI, had not sustained any permanent disability to either his left knee or lower back as a result of his March 1, 2018 work accident.

Petitioner testified that he underwent a Functional Capacity Assessment ("FCA") on May 3, 2019 at ATI Physical Therapy on referral by his attorney (PX #9). The FCA was noted as valid although the assessor did not have Petitioner's job description. The assessor relied on DOT coding, which indicated Petitioner's job required HEAVY physical demand. Petitioner demonstrated a LIGHT to MEDIUM physical demand capability, which fell below DOT descriptions and the client's self-stated level.

Petitioner testified the FCA had found him capable of performing light to medium work and that his job as a floor finisher was heavy work. He testified that since being put on permanent restrictions he has not been approved for vocational rehabilitation services and that he needs assistance finding work within his restrictions.

Petitioner returned to Dr. Silver May 7, 2019. Dr. Silver reviewed the "FCE", noting Petitioner was unable to squat, kneel, crawl, or climb. Petitioner had lifting restrictions regarding his back, which were permanent. He also noted that Petitioner was limited to 10 minutes standing, sitting for 15 minutes, and walking for short distances only. Dr. Silver noted he was not treating Petitioner's back. Dr. Silver continued with previously prescribed medication.

Petitioner testified that on May 7 Dr. Silver placed him at maximum medical improvement and allowed him to return to work within the limits of the FCA.

Dr. Silver's last note was dated July 16, 2019. It was a summary of Petitioner's case to a claims representative and not from a clinical visit. Dr. Silver noted that he returned Petitioner to normal work activities on January 14, 2019 due to his improvement. Petitioner's situation subsequently deteriorated significantly which resulted in permanent restrictions. Dr. Silver also summarized the "FCE" findings as well as current medications.

Petitioner testified he has not seen Dr. Silver or Dr. Glaser since 2019. He testified that Dr. Glaser wanted to schedule more appointments, but they were not approved.

Petitioner testified that he still feels a lot of pain in the left knee, which also keeps locking on him. His only complaint with his lower back is that sometimes he needs help from his wife getting up from the sofa. He testified that his left knee is getting worse and

that he still has back pain with numbness and tingling in both legs. He carries the cane in his right hand but uses the left hand at times when he got tired.

Petitioner testified he had no problems with his left leg prior to March 1, 2018 and while he felt pain one time in his lower back, he had no other issues. He testified to not having any new injuries to his lumbar spine since March 1, 2018.

On cross-examination Petitioner testified was always truthful to his doctors regarding the mechanism of injury, his medical history, and his symptoms. He testified that upon seeing Dr. Goldvekht on March 3, 2018 he truthfully told him about tripping over the vacuum hose, missing 3-4 steps, and landing on his knee. He told Dr. Goldvekht about hearing his knee pop and his pain in lower back.

Petitioner further testified he had asked Dr. Goldvekht for chiropractic treatment for his knee and back. He testified that when Dr. Goldvekht referred him to Dr. Glaser, he expected to keep returning to Dr. Goldvekht. Petitioner then testified he last saw Dr. Goldvekht in 2018 and that his last appointment with Dr. Glaser was in May 2019. Petitioner testified that he would agree with his records that on June 11, 2018 Dr. Goldvekht had asked him to return in 8 weeks' time but acknowledged that he did not return for treatment.

Petitioner also testified that at the time he underwent an MRI of the lower back in 2007, he was told by his doctor that "everything appeared good" and he was given some medication for the pain. He never returned for additional treatment for his lower back until March 1, 2018.

Petitioner testified that after the surgery in July 2018 his left knee symptoms improved a little bit, but that he told Dr. Silver he continued to have ongoing pain and locking. He testified that he informed Dr. Silver of these symptoms during the visit in September 2018 and also on January 10, 2019 when Dr. Silver released him to full duty work. Petitioner testified that on January 10, 2019 he informed Dr. Silver of the ongoing left knee pain. He testified that he was limping at the time and also using a cane during that visit. He testified to informing Dr. Silver that he was "in a lot of pain" on January 10, 2019 and that he was not ready to go back to work.

Petitioner also testified again that he usually held his cane in the right hand and rarely used his left hand for this purpose. When asked if there were times when he attended a doctor's appointment without a cane, Petitioner testified he had his cane most of the time.

Petitioner testified he wanted to return to Dr. Glaser but that had been unable to do so due to the lack of approval. He was aware that Dr. Gleason had opined he did not need any treatment for his lower back as of July 2018 and that he had continued to see Dr. Glaser for another 10 months thereafter. Petitioner testified he needed medical

attention for his knee and lower back but that he had not tried seeking any care for either of those conditions. He also testified that he want vocational services.

Dr. Ronald Silver testified by evidence deposition on October 22, 2019 ((PX #7). Dr. Silver is a board-certified orthopedic surgeon. He limits his practice to orthopedic surgery of the shoulder and the knee. He refreshed his memory with Petitioner's medical chart.

Dr. Silver described various mechanisms which can cause a torn meniscus, such as twisting the knee, hyper-extending or hyper-flexing the knee, and angular deformities.

Dr. Silver testified that he first saw Petitioner on March 22, 2018. Petitioner gave a history of working as a floor finisher when he became entangled with the hose of the vacuum he was using and then fell down 3 to 4 stairs. He twisted and jammed his left knee as he landed. Petitioner felt a cracking sensation as he landed. Petitioner reported that he had other injuries, but Dr. Silver concentrated solely on the left knee. Dr. Silver stated that he had no opinions regarding any other injury.

Petitioner reported that his left knee was normal before the accident. He denied any previous medical care, treatment, or symptoms prior to the accident. Petitioner had been treating with a cane, physical therapy, and anti-inflammatory medication before consulting Dr. Silver. He reported swelling, clicking, popping, and giving way of his left knee.

On examination Dr. Silver noted lateral joint line tenderness, a positive McMurray's sign, and effusion. Motion of the knee was painful beyond 90°, noting 135° is normal. Dr. Silver opined that Petitioner tore his lateral meniscus due to the work injury on March 1, 2018. He added that the mechanism described was something that could cause a meniscus tear.

Dr. Silver opined that the only way to treat a torn meniscus is to perform arthroscopic surgery because a meniscus has no physiologic ability to heal itself. He performed the surgery at Elmwood Park Same Day Surgery July 27, 2018. The postoperative diagnosis confirmed a torn lateral meniscus. Dr. Silver added that Petitioner had cracked the cartilage under the kneecap. He also noted there was scar tissue and synovitis. Dr. Silver opined that his diagnosis was related to Petitioner's injury at work. Respondent's *Ghere* objection relating to causation was overruled.

Dr. Silver added that the torn meniscus will cause tissue to inflame which causes synovitis. Further, he testified that scar tissue can form from the meniscus tear, which can be missed on an MRI.

Dr. Silver testified that in follow up August 2, 2018 he evaluated Petitioner for postoperative complications and recommended physical therapy. Dr. Silver noted Petitioner was making reasonable progress in follow-up on September 13. Petitioner was

to continue with physical therapy. Dr. Silver also released Petitioner to sedentary work which was not consistent with the job as a floor finisher. Dr. Silver continued to restrict Petitioner's work through January 14, 2019 when it was decided to give regular work a try.

Petitioner returned to Dr. Silver on May 7, 2019. Petitioner had a recurrence of severe pain after attempting normal work activities. Dr. Silver obtained a Functional Capacity Evaluation (FCE) which demonstrated Petitioner's inability to squat, kneel, crawl, or climb on a permanent basis. It also noted Petitioner was limited to standing for 10 minutes, sitting for 15 minutes, and walking only short distances. Dr. Silver noted that lifting restrictions were applicable to Petitioner's spine condition, for which he had no opinion.

Dr. Silver opined that Petitioner's restrictions regarding squatting, kneeling, crawling, or climbing, as well as the sitting and standing restrictions, were permanent. Dr. Silver testified that he relied on the FCE because of its objective nature and being the "gold standard" for understanding what a person's capable of doing. He added that FCE's are validity tested, noting that Petitioner's FCE was valid and that Petitioner's restrictions were causally related to Petitioner's work accident.

On cross-examination Dr. Silver testified that he did not review Dr. Goldvekht's records. He was unaware that Petitioner told Dr. Goldvekht that he had missed just one step on the date of injury rather than the three to four steps he reported. Dr. Silver did not find that discrepancy significant. He testified that falling down one or two or three or four steps could easily cause a torn meniscus.

Dr. Silver testified that he gave work restrictions because Petitioner was unable to perform his work because of the pain and swelling. He added that because of prescribed opioid medication it was not safe for Petitioner to work under those conditions. He further explained that it was too painful for Petitioner to sit or stand for any length of time as well as being unable to squat or kneel or crawl. Dr. Silver confirmed that Petitioner's left knee was stable but added that a sense of the knee giving way was not necessarily evidence of instability.

Dr. Silver released Petitioner to limited work December 6, 2018. He confirmed that he discharged Petitioner from his care PRN on January 10, 2019. He also released Petitioner to return to full duty work without restrictions. He testified that on January 10 Petitioner was not limping or using a cane. He noted that Petitioner was walking normally and did not complain of pain or instability. Dr. Silver believed that Petitioner's symptoms had resolved by then and that he was at MMI.

Dr. Silver further testified that Petitioner returned February 14, 2019 complaining of severe knee pain for the past eight days. Petitioner reported having some discomfort since the last visit and that it got really bad eight days before the visit. Dr. Silver admitted

that he did not note the reported continued discomfort in his medical record, but that it was his recollection. Dr. Silver also testified that he asked Petitioner on February 14 whether he had reinjured his knee but admitted that he did not record that in his chart. Dr. Silver noted that Petitioner had not been working but opined that activities of daily living caused Petitioner's condition to get worse.

Dr. Silver continued to opine that Petitioner's renewed complaints and symptoms on February 14, 2019 were causally related to Petitioner's March 2018 work accident. He testified that this type of presentation of renewed complaints is common despite an apparent recovery such as here. He testified that there was no reinjury but was a continuation. He disputed the hypothetical possibility of Petitioner injuring his knee in an intervening event.

Dr. Silver admitted that on February 14, 2019 he did not document that Petitioner's renewed complaints were related to his work injury on March 1, 2018 because it was so obvious that it was not required. He added that some people heal and that others do not.

Dr. Silver acknowledged that the follow-up MRI only showed excessive fluid which was consistent with inflammation.

Dr. Silver testified that on May 7, 2019 he had performed a physical examination on Petitioner admitted that on February 14, 2019 he did not document that Petitioner's renewed complaints were related to his work injury on March 1, 2018 because it was so obvious that it was not required.

Dr. Silver testified that he noted on February 28, 2019 that Petitioner was unable to squat, kneel, crawl, or climb. He acknowledged that the "FCE" found Petitioner was able to squat, crawl, and climb stairs occasionally. He explained that those limitations made work impossible for Petitioner. However, he did not note that he had discussed the "FCE" with Petitioner at the May 7, 2019 visit. He further admitted that he did not note a discussion that day with Petitioner about any permanent restrictions. He also admitted his May 2019 record did not include any mention of the permanent restrictions being causally related to the March 1, 2018 injury.

Dr. Silver testified to discussions with Petitioner and physical examinations that were no documented in his records. He added that after 40 years of practice he knew what needed to be included in his medical record. He testified to having experience with patients who got injured at work and with the Workers' Compensation process. He also testified that he sees an average of 100 patients a week.

On re-direct examination Dr. Silver reiterated his statement that it is common for symptoms to recur from nothing other than activities of daily living. On further questioning he remembered that he had read Petitioner's job description in the "FCE".

He then reiterated his opinion that Petitioner had permanent restrictions related to his original work injury that prevented him from returning to his previous job.

Dr. Scott Glaser testified by evidence deposition on January 14, 2020 (PX #8). Dr. Glaser specializes in interventional pain management. He is board-certified in anesthesiology and in interventional pain management. He treats pain and trauma or degenerative conditions with minimally invasive procedures. Dr. Glaser refreshed his memory regarding Petitioner's care by reviewing the medical chart.

Dr. Glaser first saw Petitioner May 21, 2018. Petitioner gave a history of injuring his back after falling down a few steps. He complained of frequent numbness and pain in both legs and that therapy had not helped. Petitioner reported he was using a cane secondary to his knee pain and back pain. He also had a torn meniscus.

Dr. Glaser testified he performed a physical examination on Petitioner even though such exams on "patients with back and leg pain don't yield that much" in diagnosing the cause of pain. On examination Petitioner had tenderness on palpation of his back in different areas. He had limited range of motion "in different ways." Provocative testing showed some evidence of nerve inflammation at the level of the lumbar spine but there was no neurologic deficit.

Dr Glaser testified that he reviewed a lumbar MRI, although he did not remember if he reviewed the original film. He noted that MRIs do not help in diagnosing pain. MRIs will show structures that may or may not be painful. He noted that Petitioner had evidence of two injuries that more likely than not were not present prior to his fall. He noted that Petitioner had a large broad-based disc protrusion/herniation at L5-S1 as well as an injury to his annulus at L3-4 and L4-5, where he had disc bulges as well. Dr. Glaser based his opinion that the MRI findings were not present before the fall because Petitioner reported he was not in pain before the fall.

Dr. Glaser testified that back pain or commonly comes from facet joints rather than the disc joint, adding that an injury to the disc is accompanied by a facet joint injury as well. He diagnosed facet joint pain with nerve inflammation secondary to spinal injuries. He opined that his diagnosis was related to Petitioner's accident in March 2018 because Petitioner was not in pain prior to that accident.

Dr. Glaser testified that he does not recommend treatment. Rather, he gives the patient's three options: do nothing and live with the pain, take pills, and deal with the effects on his quality of life; minimally invasive treatment; or surgery. He added that he generally tries to talk his patients out of surgery before they do something minimally invasive. Petitioner chose the procedure with Dr. Glaser who performed bilateral lumbar transforaminal epidural steroid injections on June 19, 2018.

In follow-up on July 10, 2018 with the Nurse Practitioner Petitioner reported some relief from the injection. The Nurse Practitioner offered repeat interventions which were performed on August 21. Dr. Glaser noted Petitioner had 50% short-term relief and 20% long-term relief. Dr. Glaser noted that the two-month gap between injections was not optimal; two to three weeks is optimal. He recommended more therapy for Petitioner.

Dr. Glaser saw Petitioner again on October 17, 2018. He stated that worker's comp "takes forever to get things approved." He noted that Petitioner had just started therapy. Petitioner returned on November 28 and reported that physical therapy helped his sleep although there was no difference in his lower back pain.

On March 16, 2019 Petitioner reported lower back pain on a daily basis. Pain ranged from 7 to 10, which significantly affected his quality of life. Dr. Glaser offered a third epidural steroid injection, which had not been done. Dr. Glaser last saw Petitioner May 9, 2019. The doctor continued with his prior recommendations at that time.

Dr. Glaser further testified that almost everybody gets relief of their radicular pain with two or three steroid injections over a month or month and a half. He added that patients frequently required treatments to their facet joints. He added that Petitioner will, more likely than not, require treatment of his facet joints. He noted Petitioner's care had been interrupted and delayed by IMEs and "the whole worker's comp system."

Respondent objected to Dr. Glaser's speculative testimony that while Petitioner was on the narcotic Tramadol, he will probably get used to it and need a stronger narcotic. The objection was sustained.

Dr. Glaser acknowledged that he had authored a narrative report in response to the evaluation by the IME doctor in which he disagreed with the diagnosis by the IME physician. He disputed the diagnosis of "[No] positive objective findings on physical exam with respect to the lower back," because it is not a diagnosis. He called it a "ludicrous statement." He testified that physical exams and MRIs did not provide information about the cause of pain and the highest level of diagnosis for what was causing somebody's pain was their response to interventions. He noted there is no diagnostic objective finding for a headache and yet they do exist. He noted that orthopedic doctors and IME doctors are obsessed with objective findings. He noted it was sophistry, like gas lighting, and had "nothing to do with anything."

Dr. Glaser further stated that he did not perform epidural steroid injections for someone who merely has suffered a strain. He noted that muscles get better, but that joints and nerves do not get blood flow that muscles get. That is why so much chronic pain occurs in joints and nerves, knees, hips, shoulders, and all the joints of the spine. Dr. Glaser added, "[T]hey never finish the – – Once they're injured, the cartilage is injured, it doesn't go through the complete inflammatory process where you actually lead to healing because the stems – – there's not enough stem cells getting to the injury."

Finally, Dr. Glaser testified that the treatment he provided was causally related to Petitioner's accident in March 2018.

On cross-examination Dr. Glaser testified he did not remember whether Petitioner had been referred to him by a physician and that while he sometimes noted in his records whether a patient was a referral, sometimes he did not. At first Dr. Glaser was unsure whether he was aware petitioner had seen Dr. Goldvekht but then recalled that he saw Petitioner at APM (Advanced Physical Medicine) and therefore had seen Petitioner's records.

Dr. Glaser reiterated that he did not remember whether he saw the actual MRI scan of Petitioner or just reviewed the radiologist's report. He testified it was not vital for him to see the films of the actual scan in this case.

Dr. Glaser explained that his diagnosis of facet syndrome without myelopathy meant the facet joints were not affecting the spinal cord. He testified the epidural steroid injections (ESI) did not provide long-lasting relief because it was possible the L4-5 and L5-S1 levels were not the source of pain and that L3-4 was also a source of radicular pain. He noted that an initial ESI provides relief in the majority of patients. He stated that while unlikely, there was a possibility Petitioner was exaggerating his symptoms.

Dr. Glaser testified that when he saw Petitioner on August 15, he knew Petitioner had undergone knee surgery two weeks before. He testified that he would not necessarily expect Petitioner to be on pain medication because it depended on whether the patient was still having pain. He also acknowledged that he noted a "zero" disability score but not on August 15.

Dr. Glaser further testified that Petitioner reported 20% relief with the second round of injections. During the October 17, 2018 visit Petitioner described his pain during self-care as 1 out of 10, and that a score of zero meant the pain did not disable him from taking care of himself or activities of daily living.

Dr. Glaser acknowledged that he wrote a report in response to the IME report, likely on September 6, 2018. It was in response to Dr. Gleason's July 24, 2018 IME, not Dr. Neal's IME. He testified that he disagreed Dr. Gleason's opinions and had argued when a patient's symptoms persisted, there must be a severe underlying injury. He noted that Dr. Gleason had not really identified this injury in Petitioner's case. Dr. Glaser supported his argument with citation to interventional pain management literature, particularly authored by Dr. Laxmaiah Manchikanti, and the guidelines within the National Guideline Clearinghouse.

Dr. Glaser testified that the epidural injections, the physical therapy, and pain medication had not resolved Petitioner's symptoms because they were not expected to resolve the pain. He added that petitioner had chronic back pain from his permanent

injuries from his fall. He had not had appropriate treatment "because of the worker's comp system." He added that due to treatment delays he was beginning to think Petitioner may end up having back surgery, although acknowledging that was speculative.

Dr. Glaser testified that there are no objective medical tests to measure pain but added that sometimes the reason for the pain can be diagnosed. He further testified that Petitioner has facetogenic and discogenic pain, but that the majority of patients suffer facet joint pain primarily. In his opinion Petitioner's decision to undergo epidural injections was proof that there was no symptom magnification.

Dr. Glaser further testified unless there was a permanent neurologic deficit radicular pain is inflammation and can shift from side to side depending on daily activity. He reiterated his opinion that Petitioner injured facet joints and this joints in his lumbar spine which caused radicular symptoms, and which were all secondary to the fall because he was in no pain prior to the fall.

Dr. Glaser testified the last time Petitioner saw him in May 2019 he reported pain that was 10 out of 10 at its worst and 7 out of 10, when least severe. He testified that he would expect Petitioner would be doing something for his symptoms but did not know what.

On redirect examination Dr. Glaser explained ODG guidelines and their use by worker's comp companies. He stated that ODG guidelines were poorly created. He added that the American Society of Interventional Pain Physicians had pointed out flaws in the guidelines. On re all cross-examination Dr. Glaser acknowledged that positions were consulted in creating ODG guidelines.

Dr. Thomas Gleason testified by evidence deposition on June 16, 2020 (RX #7). Dr. Gleason is a board-certified orthopedic surgeon. He performs two to three IMEs a week. He described the process of an IME as an examination of the individual with a focus on a particular part of the body. He takes a history from the individual, perform an examination, review available radiological imaging, review available medical records, and formulate a diagnosis and render an opinion. Dr. Gleason performed three IMEs of Petitioner and refreshed his memory from the reports of those IMEs.

Dr. Gleason first examined Petitioner on July 24, 2018 for his lower back. He testified that Petitioner reported on March 1, 2018 he got caught in the hose of the vacuum he was working with, which caused him to fall forward, missing 3 to 4 steps, and twisting his left knee and back. Petitioner was taking Tramadol, which, in his opinion, was not recommended for chronic pain. Petitioner had reported constant lower back pain which had remained the same since March 1, 2018.

Dr. Gleason testified he reviewed the MRI scan of the lumbar spine performed on March 23, 2018, which revealed bulging at L3-4-5 with small central protrusions

indenting the sac and mild central spinal stenosis and foraminal narrowing. There was diffuse degenerative disc disease with associated disc space narrowing. The scan was otherwise unremarkable.

Dr. Gleason opined that Petitioner did not exhibit objective findings on physical examination with respect to the lower back. He explained that Petitioner demonstrated inconsistent and contradictory results on examination, particularly the inconsistent and contradictory findings on the Britton test and straight-leg raise. He added that there was no known pathoanatomical explanation for Petitioner's reported diminished sensation over the entire right leg and the MRI findings. Also, the diffuse diminished pinprick sensation was inconsistent with normal strength and reflexes.

Dr. Gleason opined, based on this examination, that Petitioner sustained a soft-tissue type strain and/or a temporary exacerbation of a pre-existing condition. He did not believe there was a permanent aggravation. He testified this kind of injury would resolve within a relatively brief period of time. Therefore, any treatment undergone by Petitioner after June 11, 2018 was excessive, unnecessary, and unrelated to the reported March 1, 2018 injury. Dr. Gleason opined that Petitioner did not need any further limitations or work restrictions regarding his low back that were related to his March 1, 2018 accident. Dr. Gleason testified Petitioner could return to work without restrictions with respect to the lower back and he had reached MMI about 2 to 3 months after the date of injury of March 1, 2018.

Dr. Gleason testified he examined Petitioner with respect to the left knee on December 18, 2018. He testified that Petitioner gave a slightly different history of injury than before. Petitioner reported that he had landed on his left foot where he had previously reported landing on his right foot. Dr. Gleason recounted Dr. Silver's arthroscopic surgery on July 27, 2018 and recommendation of further physical therapy. Petitioner denied taking medication for his knee. Petitioner presented with complaints of knee pain which had improved since surgery. However, Petitioner complained of continued popping and giving out, as well as numbness over the front of the knee down to the anterior upper quarter of the calf.

Dr. Gleason opined that the work injury of March 1, 2018 caused a symptomatic tear of the left lateral meniscus. The treatment, including the arthroscopy, so far had been reasonable and necessary, but no additional treatment was needed. Dr. Gleason encouraged a home exercise program and weight loss. He opined that over-the-counter medication or, alternatively, long-term nonsteroidal anti-inflammatory medication might be beneficial. Dr. Gleason testified that Petitioner did not need work restrictions or limitations and could return to full duty work with respect to the left knee, and he had reached MMI with respect to his left knee as of November 30, 2018.

Dr. Gleason testified he saw Petitioner one last time on April 23, 2019 for the lower back and left knee. He reviewed Petitioner's medical course since the last IME. Petitioner had had two lumbar epidural steroid injections by Dr. Glaser, which gave relief for about a week and a half. He was awaiting approval of a third epidural. Additional physical therapy was denied approval. Petitioner also reported that he had returned to Dr. Silver with complaints with around the kneecap although pain over the outer aspect of the knee was improved. He was taking Tramadol twice a day and Meloxicam daily. He also was Lidocaine cream once a day as well as Diclofenac cream twice daily. Petitioner reported that he had been released to work by Dr. Silver but kept off work by Dr. Glaser. Dr. Gleason testified that he believed Tramadol twice daily was excessive.

On exam Petitioner complained of left knee which improved after surgery but was now painful over the kneecap and front of the knee. He also had intermittent low back pain going down the entire right leg since March 1, 2018. Dr. Gleason reviewed radiological studies, including the two left knees MRIs, reiterating his findings. The "2/16/18" [*sic*] (February 26, 2019) MRI showed meniscus postoperative changes and lateral subluxation of the patella with chondromalacia involving the lateral patellofemoral joint. He also reviewed the March 23, 2018 lumbar MRI which showed diffuse degenerative disc disease with disc space narrowing.

Dr. Gleason testified it was his opinion Petitioner's current symptoms and condition in the left knee were unrelated to the work accident on March 1, 2018, but instead were caused by chondromalacia of the patella, which had been completely absent in the March 2018 MRI scan. He explained that Petitioner's reported symptoms after the work injury, in conjunction with the results of the physical examination, and in conjunction with the initial MRI scan, did not suggest chondromalacia of the patella. Furthermore, Dr. Gleason testified that no such pathology of the patella was noted by Dr. Silver during his surgery.

Dr. Gleason further testified that Petitioner's subjective complaints outweighed objective medical because of inconsistencies in Petitioner's gait and his reaction to requested movement, suggestive of overreaction. Dr. Gleason also testified that on measuring active motion of both knees, Petitioner only bent his knees to 90° on the first request and then when measured a second time, both his knees bent to 130°. Dr. Gleason testified that Petitioner did not need any work restrictions with respect to his left knee and that he was at MMI by the previous examination of December 18, 2018. He added that Petitioner did not require any further institutionalized/formalized treatment related to the March 1, 2018 work injury.

With respect to the lower back issues, Dr. Gleason testified Petitioner's complaints were not supported by objective findings on physical examination. He testified he had reviewed the narrative report from Dr. Glaser in response to his IME. Dr. Gleason disagreed with Dr. Glaser because he was not aware of Level 1 evidence-based medical

literature supporting not one, but two epidural steroid injections, when the first one did not provide relief for more than a week and a half, occasionally when there is intermittent low back pain in the absence of objective findings on physical examination. He testified that his examination of Petitioner's lower back in April 2019 did not give any reason to revise his opinion from the July 2018 examination. Dr. Gleason reiterated that he found Petitioner at MMI by July 24, 2018.

Dr. Gleason testified he would be surprised to learn Petitioner was placed on permanent restrictions by a valid "FCE". He would need some restrictions with respect to the left knee as a result of the symptomatic chondromalacia and patella malalignment, but those restrictions would be unrelated to the March 1, 2018 work injury. He added that Petitioner would not have any restrictions with respect to the lower back.

On cross-examination Dr. Gleason acknowledged that he had not seen the "FCE" report before the day of his deposition. He described the FCE process is one intended to establish objective findings of functional capacity but that there were subjective components. However, Petitioner's subjective complaints outweighed the objective findings.

In further cross-examination Dr. Gleason testified that an injury to the meniscus was not sufficient to aggravate or accelerate chondromalacia of the patella. He explained that chondromalacia is a naturally occurring degeneration. The cartilage degenerates and softens and then becomes somewhat frayed, developing crevices, and ultimately resulting in complete eburnation down to the bone as a natural part of aging. Dr. Gleason opined that chondromalacia may sometimes be the result of trauma if there is a direct trauma resulting in a bone bruise and associated cartilage damage. However, in his opinion that Petitioner's chondromalacia was not related to his fall down a set of stairs because he had only twisted his knee when landing on his foot.

Dr. Gleason testified that the "FCE" found Petitioner at the light to medium physical demand level. He noted Petitioner terminated most activities with reports of pulling and locking of his low back with no explanation. He again noted that Petitioner had no positive objective findings in his low back adding that his back was not injured in the accident. He also testified that he was unsure why Petitioner had pain and giving out of the left knee when demonstrating poor body mechanics. He noted that Petitioner had demonstrated compensatory patterns at the "FCE", such as bracing his weight against his body, shifting his weight to the right side, and bracing himself against the table, which he did not during the IMEs. Dr. Gleason a acknowledged that he did not examine Petitioner while pushing or pulling various weights.

On further cross-examination Dr. Gleason testified that he could not imagine another orthopedic surgeon who would not note the inconsistencies and contradictions between Petitioner's negative Britton test and resistance of straight-leg raise at 15°.

Dr. Gleason acknowledged that he performs 2 to 3 IMEs per week, of which about 80% of which are for the defense.

Respondent's Exhibit #8 was admitted without objection. It comprised an investigator's report of surveillance of Petitioner on June 19 and June 23, 2020 and a DVD of video recordings of Petitioner on those days. The investigator's report encompassed a longer period of surveillance than depicted on the video recordings. Investigator. The investigator did not note observations or impressions of Petitioner's appearance of limitation or lack of limitation of movement. The video recordings on June 19 depicted Petitioner walking slowly with an apparent limp and right-handed use of a cane. A recording later that day depicted Petitioner exhibiting no apparent limitation in walking while holding a cane in his right hand. The recording of Petitioner on June 23 was insufficient to assess whether Petitioner was walking with or without limitation.

Respondent's Exhibit #9, a ledger of benefits paid, was admitted without objection. RX #9 reflected various paycodes without identifying, defining, or explaining the paycodes. The Arbitrator could not evaluate the data within RX #9 without identification, definition, or explanation.

Corrected CONCLUSION OF LAW

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

After weighing all the evidence, including Petitioner's testimony, Petitioner's medical records, and the opinions of various physicians, the Arbitrator finds that Petitioner failed to prove that his claimed current condition of ill-being with regard to his left knee and the claimed current condition of ill-being with regard to his lower back were causally related to his work injury on March 1, 2018. In weighing the evidence, the Arbitrator found Petitioner's credibility was compromised by inconsistencies and contradictions in the medical histories he gave to various physicians. The Arbitrator also found that the opinions of Dr. Thomas Gleason were more reasonable and persuasive than the opinions of Drs. Ronald Silver and Scott Glaser.

It was not disputed that Petitioner sustained injuries from an accident while working. It was not genuinely disputed that Petitioner sustained a torn lateral meniscus in his left knee which required arthroscopic repair and rehabilitative post-operative therapy. It is clear that Petitioner fell down some stairs while at work on March 1, 2018. He variously reported that he missed a step, tripped on a cord, and tripped on the hose of the vacuum machine he was operating. He variously reported falling down one or two or three or four steps. There was evidence in the reports of various IMEs that Petitioner's subjective complaints were exaggerated and nonanatomic.

The clinical notes of Dr. Silver do not document complaints of low back pain but

once or of parallel medical care for low back pain. The clinical notes of Dr. Glaser do not document complaints of specific left knee pain or of parallel medical care for left knee pain. There are no notes indicating that Petitioner disclosed his care with Dr. Silver to Dr. Glaser or that he disclosed his care with Dr. Glaser to Dr. Silver. There are no notes in either medical chart indicating that Drs. Silver or Glaser communicated with the other or that they coordinated Petitioner's medical care or physical therapy or medication.

Equally important, Petitioner did not disclose to his treating physicians that he had had an episode of prior low back complaints for which he had to have an MRI. The reported findings on the prior MRI demonstrated degenerative disc disease in the lumbar spine, a condition which may well have affected the causation opinions of his treating physicians. In addition, Petitioner cancelled or missed numerous scheduled physical therapy appointments. This is suggestive of Petitioner's lack of commitment to his own recovery or that his condition was not as severe as claimed.

As stated before, there is no dispute that Petitioner sustained a torn lateral meniscus in his left knee that required arthroscopic repair and post-operative therapy. There is little dispute that Petitioner also sustained an injury to his lower back, the full nature of which is disputed.

The disputed issue regarding Petitioner's left knee involves Dr. Silver's opinion that subsequent to his assessment on January 10, 2019 that Petitioner was at MMI and capable to full duty work countered by his opinion that Petitioner's new complaints on February 14, 2019 were causally related to the work accident on March 1, 2018. Dr. Silver's own clinical records do not support a causation opinion connecting the new symptoms on February 14 to the work accident.

Petitioner initially injured his left lateral meniscus which required arthroscopic repair. Petitioner's complaints and care up to January 10, 2019 were focused on the left lateral meniscus. His presenting symptoms in February 2019 were related to the patella. There was no assessment or diagnosis relating to the patella prior to February 2019. There were no meniscus related symptoms documented in February 2019 or later. Despite his questionable causation opinion, Dr. Silver testified that Petitioner's renewed complaints and the patellar chondromalacia could be related to normal activities.

The credibility and persuasiveness of Dr. Silver's opinions are further undermined by his plainly unbelievable testimony regarding his clinical documentation or, rather, his lack of clinical documentation. At his deposition Dr. Silver testified to an independent recall of a wide variety statements attributed to Petitioner which were not recorded as well as a wide variety of clinical findings which were not documented. The Arbitrator finds this claimed ability to independently recall such critical clinical facts unbelievable in light of his admitted volume of practice and considering the passage of time. The Arbitrator further notes the wholesale lack of documentation of prescribed medications, particularly dosages. This lack of adherence to accepted standards of practice regarding management of addictive medication does not help his credibility.

Petitioner was examined three times pursuant to §12 of the Act by orthopedic surgeon Dr. Thomas Gleason. Dr. Gleason assessed Petitioner's left knee December 18, 2018 and April 23, 2019. What distinguished Dr. Gleason's examinations was his review of medical records that Dr. Silver had not. Dr. Gleason performed thorough reviews of Petitioner's treatment for his claimed injuries as well as performing thorough clinical examinations. Dr. Gleason's reviews revealed numerous contradictions and inconsistencies in Petitioner's case which bolstered his opinions. The Arbitrator therefore adopts Dr. Gleason's opinions regarding Petitioner's left knee, except for the date of MMI. The Arbitrator, giving Petitioner the benefit of the doubt and noting Petitioner's documented continuing complaints, finds Petitioner's left knee reached MMI January 10, 2019.

Accordingly, the Arbitrator finds that Petitioner proved that the condition of ill-being in his left knee was causally related to his work accident on March 1, 2018 but that that condition of ill-being was resolved by January 10, 2019 when Petitioner reached MMI was capable of returning to full duty work. However, the Arbitrator also finds that Petitioner failed to prove that the claimed condition of ill-being in his left knee which manifested in symptoms in February 2019 was causally related to his work accident.

The Arbitrator also finds that Petitioner failed to prove that his claimed current condition of low back pain is causally related to his work accident on March 1, 2018. The evidence was clear that Petitioner had a pre-existing degenerative condition in his low back as evidenced by his 2007 MRI demonstrating lumbar spine degenerative disc disease. Petitioner relies on the causation opinion of Dr. Scott Glaser in asserting his claim. The Arbitrator does not find Dr. Glaser's opinion credible or persuasive.

As noted above, Petitioner did not give an accurate history of prior low back problems, problems significant enough to warrant an MRI. In addition, Dr. Glaser did not review any of Petitioner's medical records from concurrent treaters, nor did he believe such review was necessary. Here, we have a patient consulting three different physicians, not to mention two different providers of physical therapy. The records are replete with notations of Petitioner taking prescription medications including narcotics. There was no apparent effort by Dr. Glaser to clarify these medications, who prescribed them or in what dosage. This suggests an unacceptable breach of the standard of care of a pain management specialist. It is clear that Dr. Glaser lacked a full understanding of Petitioner's medical picture, including the low back.

The Arbitrator also took note of Dr. Glaser's demeanor during his deposition. The Arbitrator acknowledges that assessing the demeanor of a deposition deponent is quite difficult. Here, the record clearly demonstrated Dr. Glaser's argumentative and contentious behavior. Likewise, he testified that his opinions should be accepted because "I'm the doctor." A witness's credibility may be judged by their demeanor as well as other factors.

Dr. Gleason assessed Petitioner's lower back condition on July 24, 2018 and April 23, 2019. As noted above, Dr. Gleason had the advantage of reviewing Petitioner's

medical records from Drs. Aleksandr, Silver, and Glaser. Dr. Gleason found contradictions and inconsistencies in clinical examinations of Petitioner, particularly magnified complaints and nonanatomic responses. It is noteworthy that Dr. Bryan Neal found that same magnification of complaints and nonanatomic responses. Dr. Gleason opined that Petitioner sustained a soft tissue low back strain or temporary aggravation of a pre-existing condition. He opined that there was no permanent aggravation of the pre-existing low back condition. Dr. Gleason further opined that Petitioner had reached MMI with regard to his low back and that he did not require medical intervention for his back after June 11, 2018. As a result, Dr. Gleason found that Petitioner could return to full duty work due the MMI condition of his back.

The Arbitrator did not find Dr. Glaser's causation opinion credible or reasonable or persuasive. Dr. Gleason's opinions are reliant on a broader scope of review of Petitioner's claimed medical condition and treatments as well as his thorough clinical exams. His opinions are consistent with the findings and opinions of the other §12 examining physician. Accordingly, the Arbitrator adopts Dr. Gleason's opinions and finds that Petitioner only proved a temporary aggravation of a pre-existing degenerative condition but failed to prove that his claimed current condition of ill-being in his lower back is causally related to his work accident on March 1, 2018.

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 received emergent care in the Emergency Department of Respondent the day of his accident. That care and treatment was clearly reasonable and necessary.

Petitioner followed up with Dr. Aleksandr Goldvekht on March 3, 2018. Dr. Goldvekht diagnoses were vague and descriptive only of the location of Petitioner's subjective complaints: lumbar disc with left lower extremity radiculitis and left knee injury. Dr. Goldvekht prescribed physical therapy as well as non-steroidal anti-inflammatory medication (NSAID), muscle relaxant medication, and medication for gastric upset from NSAIDs without documenting gastric upset symptoms.

Curiously, Dr. Goldvekht also prescribed Terocin patches to avoid developing dependence on opioids and urine toxicology testing. The Arbitrator finds this regimen highly questionable because no opioids were prescribed. This practice of prescribing medication where there were no symptoms (the gastric upset medication) and the wholly unnecessary ordering of Terocin patches and urine testing in the absence of opioid prescriptions undermines the credibility of any of Dr. Goldvekht's causation opinions.

It was not disputed that the care and treatment provided by Dr. Goldvekht was reasonable and necessary. However, the Arbitrator finds that Petitioner failed to prove the reasonableness and necessity of prescribing Terocin patches and urine toxicology screening. Unfortunately, the Arbitrator cannot divine the separate charges for the

unnecessary medication and procedures.

Similarly, the Arbitrator finds Petitioner recovered from his left knee injury and was at MMI when he saw Dr. Silver on January 10, 2019, when the knee was asymptomatic and when Dr. Silver released him to full duty work. The new symptoms Petitioner complained of in February 2019 were not related to his work accident on March 1, 2018 but were caused by the activities of daily living, as suggested by Dr. Silver in his deposition. Further, Dr. Silver did not give a definitive opinion that the new complaints in February 2019 were causally related to the work accident. He testified that the new condition, patellar chondromalacia, was related activities of daily living. Therefore, the Arbitrator finds that Petitioner failed to prove that the treatment by Dr. Silver for these new symptoms starting in February 2019 until his last appointment with Dr. Silver in July 2019, including the MRI scan and the FCA, were causally related to the work accident of March 1, 2018. The Arbitrator denies payment for medical care and therapy for the left knee after January 10, 2019.

Dr. Gleason opined that the medical care and treatment of Petitioner's lower back complaints were reasonable and necessary up to June 11, 2018. However, in light of adopting Dr. Gleason's reasonable causation opinion that Petitioner was at MMI and required no further medical care for his lower back after June 11, 2018 the Arbitrator denies payment of medical care and treatment for Petitioner's lower back after June 11, 2018.

The Arbitrator also finds that Petitioner failed to prove that any outstanding bills from Rx Solutions, in the amount of $42,319.44, and from Persistent Rx, in the amount of $13,231.72, were reasonable or necessary. The Arbitrator notes that no bills or billing ledgers from Rx Solutions in any amount were admitted in evidence. The Arbitrator further notes that the billing from Persistent Rx in the amount of $13,231.72, PX #10, was not supported by Petitioner's testimony or the medical records. As noted above, the records admitted in evidence did not confirm who prescribed certain medications or the dosage of such medications or when the medications were actually prescribed the appropriate monitoring of addictive medications. Further, the Persistent Rx billings were dated July 22 and August 28, 2019, dates which were after the date the Arbitrator found the evidence showed Petitioner was at MMI and required no further medical care.

In addition, a ledger reflecting dispensing of cyclobenzaprine, Meloxicam, pantoprazole, Tramadol, and Terocin patches was included in Petitioner's Exhibit #1. However, the dates when these medications were ordered or dispensed nor the charges for these medications were noted. Correspondingly, Petitioner failed to prove any charges for these medications were reasonable and necessary.

K: Is Petitioner entitled to prospective vocational rehabilitation?

The Arbitrator previously found that the evidence showed Petitioner was at MMI with regard to his lower back and also with regard to his left knee. The Arbitrator found the opinions of Dr. Thomas Gleason that Petitioner was capable of full duty work to be reasonable and persuasive and adopted those opinions. Therefore, the Arbitrator finds that Petitioner failed to prove that he is entitled to vocational rehabilitative services.

L: What temporary benefits are in dispute? TTD/Maintenance

The Arbitrator previously found that the evidence established that Petitioner was at MMI for his low back by June 11, 2018 and was at MMI for his left knee by January 10, 2019. Petitioner was taken off work by Dr. Goldvehkt on March 3, 2018. Dr. Gleason found that Petitioner was at MMI and could return to fully duty work with regard to the lower back at the July 24, 2018 IME. Dr. Silver found Petitioner was at MMI with regard to the left knee and released Petitioner to full duty work effective January 14, 2019.

The evidence established that Petitioner was entitled to 45 & 1/7 weeks of Total Temporary Disability benefits, at a rate of $410.01/week. Respondent is entitled to a credit for benefits previously paid.

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

The parties agreed and stipulated that if the Arbitrator finds that Petitioner fails to prove that he is entitled to vocational rehabilitation and maintenance then that the Arbitrator make a determination of permanency. Inasmuch as the Arbitrator found that Petitioner is at MMI and therefore not entitled to vocational rehabilitation services the Arbitrator will assess Petitioner's in accord with §8.1b of the Act:

i): No AMA Impairment Rating was offered in evidence for either of Petitioner's claimed injuries. The Arbitrator could not give any weight to this factor.

ii) Petitioner was employed as a maintenance floor finisher. The job has been described as requiring heavy physical demand. Although Petitioner was found capable of returning to full duty work by Dr. Gleason he has not returned to work. The Arbitrator gives moderate weight to this factor.

iii) Petitioner has not returned to work since the day of his accident. His treating physicians have not released him for return to work although Respondent's §12 examining physician has opined that Petitioner was capable of returning to full duty work. In light of the findings that Petitioner is at MMI and capable of full duty work there was no credible evidence that Petitioner's earning capacity was affected by his injuries. The Arbitrator gives great weight to this factor.

iv) Petitioner was 63 years old at the time of his work accident. He had a statistical life expectancy of approximately 21 years. In light of Petitioner's current condition as evident from the evidence the Arbitrator give less weight to this factor.

v) Petitioner did sustain compensable injuries to his left knee and to his lower back. The medical evidence, which included several IMEs, showed that Petitioner was an unreliable historian and who magnified and exaggerated his subjective complaints and limitations. Petitioner's treating physicians' opinions were unpersuasive based on poor to nonexistent clinical charting and less than credible testimony at deposition. The evidence established that Petitioner had recovered from his injuries sufficiently to return to full duty work by January 2019. The Arbitrator gives great weight to this factor.

After considering all the evidence, including the above five factors, the Arbitrator finds Petitioner sustained a permanent partial disability of **3%** loss of person-as-a-whole, **15** weeks, for the lower back strain sustained by him as a result of the March 1, 2018 work accident.

After considering all the evidence, including the above five factors, the Arbitrator finds Petitioner sustained a permanent partial disability of **12.5%** loss of the left leg, **26.875** weeks, for the torn lateral meniscus sustained by him as a result of the March 1, 2018 work accident.

Steven J. Fruth, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC031742
Case Name	DUNCAN, RICKY A v. AMEREN ILLINOIS
Consolidated Cases	17WC031742
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	22IWCC0137
Number of Pages of Decision	55
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	David Nelson
Respondent Attorney	William Lemp

DATE FILED: 4/12/2022

/s/Carolyn Doherty, Commissioner

Signature

22IWCC0137

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ricky Duncan,

Petitioner,

vs. NO: 13 WC 31742
19 IWCC 0327

Ameren Illinois,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from an order of the Circuit Court of St. Clair County. In accordance with the order of the circuit court entered on October 8, 2020, the Commission considers the issues of medical expenses, temporary total disability, and permanent total disability, and being advised of the facts and law, concludes that Petitioner is entitled to benefits pursuant to the Illinois Workers' Compensation Act for the reasons stated below.

I. PROCEDURAL BACKGROUND

Petitioner's consolidated claims (Nos. 13 WC 31742 and 17 WC 27834), both involving exposures to Petitioner's lungs, were heard by the arbitrator on June 26, 2018. In a decision filed on August 14, 2018, the arbitrator found that Petitioner proved that he suffered accidents, but failed to prove that his condition of ill-being was causally connected to the exposures at work and that Petitioner suffered only temporary exacerbations of underlying asthma. Petitioner sought a review by the Commission, which issued a Decision and Opinion on Review affirming and adopting the arbitrator's decision on June 26, 2019. Petitioner then sought administrative review in the Circuit Court of St. Clair County. On October 8, 2020, the circuit court entered an order finding a causal connection and remanding the matter "for further proceedings." *Duncan v. Ameren Illinois*, No. 19 MR 199 (Cir. Ct. St. Clair County, Oct. 8, 2020).

II. FINDINGS OF FACT

The Commission hereby incorporates by reference the "Statement of Facts" contained in the arbitration decision filed on August 14, 2018, attached hereto and made a part hereof, to the extent it does not conflict with the order filed in the Circuit Court of St. Clair County on October 8, 2020. The Commission also incorporates by reference the October 8, 2020 circuit court order, which delineates the relevant facts of the case and the court's analysis of causal connection, attached hereto and made a part hereof. Any additional findings of fact in this Decision and Order on Remand will be specifically identified in the discussion of particular issues.

III. CONCLUSIONS OF LAW

Having found that Petitioner's current condition ill-being was causally connected to his work-related exposures, the circuit court has remanded the consolidated cases to the Commission for further proceedings. Accordingly, the Commission adopts the conclusions of the circuit court regarding accident and causal connection, and makes further determinations regarding the following issues presented at trial: (a) medical expenses; (b) temporary total disability (TTD) benefits; and (c) permanent total disability (PTD) benefits.

A. Medical Expenses

The Commission first addresses Petitioner's necessary and reasonable medical expenses. Section 8(a) of the Act requires employers to pay all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of the work-related injury. 820 ILCS 305/8(a) (West 2012). 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 his 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)). If the employer fails to introduce any evidence to suggest that services rendered were not necessary or that the charges were not reasonable, an award to a claimant who presents some evidence in support of the award will be upheld. *Max Shepard, Inc. v. Industrial Comm'n*, 348 Ill. App. 3d 893, 903 (2004); *Ingalls Memorial Hospital v. Industrial Comm'n*, 241 Ill. App. 3d 710, 718 (1993).

Petitioner listed and included his claimed medical bills, totaling $47,973.55, in Petitioner's Group Exhibit 6. In the Requests for Hearing submitted into evidence as Arbitrator's Group Exhibit 1, Respondent generally disputed liability, but raised no specific objection to Petitioner's claimed medical expenses in the Requests for Hearing, during the hearing, or in its Statement of Exceptions and Supporting Brief. Accordingly, the Commission awards Petitioner the sum representing his outstanding medical expenses as stated in Petitioner's Group Exhibit 6.

In addition, despite ruling that issues beyond causal connection were moot, the Arbitrator found that Respondent is entitled to a credit of $84,415.61 under section 8(j) of the Act (820 ILCS

305/8(j) (West 2012)). Generally, there are three requirements which must be established before a section 8(j) credit can be awarded: (1) group insurance must have paid medical benefits; (2) the employer paid into the group policy; and (3) the group policy must preclude medical payments for injuries sustained in work-related accidents. *E.g.*, *Estate of Meyer v. Jewel Food Stores*, Ill. Workers' Comp. Comm'n, No. 17 WC 01604, 20 IWCC 0451 (Oct. 15, 2020). In this case, the $84,415.61 figure is written in the Request for Hearing for 13 WC 31742, opposite the paragraph on the form referring to payments made by Respondent, with no boxes checked to indicate whether this was an issue of dispute or agreement between the parties. During cross-examination, Petitioner testified that charges for his treatment, including with Dr. Peter Tuteur, Dr. Adam Anderson, and Dr. Adele Roth, were submitted to group medical insurance provided through Respondent. See Tr. 160. Respondent did not submit a copy of the group insurance policy or other evidence indicating that the policy precludes medical payments for injuries sustained in work-related accidents.

However, a claimant may waive or procedurally forfeit an issue by failing to raise it in the Petition for Review or in a timely statement of exceptions. *Jetson Midwest Maintenance v. Industrial Comm'n*, 296 Ill. App. 3d 314, 315-16 (1998). Petitioner did not raise the award of the section 8(j) credit in his Petition for Review or in his statement of exceptions on review. Accordingly, the Commission reaffirms the finding of the Arbitrator awarding Respondent a credit under section 8(j) of the Act.

B. Temporary Total Disability

The Commission next turns to address Petitioner's claim for temporary total disability (TTD) benefits. "To establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). "The dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Id*. "The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized." *Id*. at 760 (citing *Beuse v. Industrial Comm'n*, 299 Ill. App. 3d 180, 183 (1998)).

In the Request for Hearing for 13 WC 31742, Petitioner claims TTD benefits for the periods from May 12, 2014 through September 21, 2014 (19 weeks) and from October 5, 2014 through the hearing date of June 26, 2018 (194 and 3/7ths weeks). As with the medical expenses, these dates are written in beside the paragraph of the form addressing TTD benefits, with no boxes checked to indicate whether this was an issue of dispute or agreement between the parties. The writing represents "19 weeks (paid)". The writing also includes the figure of $18,954.97, which the Arbitrator awarded to Respondent as a credit for TTD benefits already paid.

Petitioner's treatment records indicate that on May 9, 2014, Dr. Tuteur concluded that it was medically contraindicated for Petitioner to return to the workplace and that the condition of irritant-induced bronchial reactivity is permanent and irreversible. PX3. Petitioner testified that he received TTD benefits after Dr. Tuteur took him off work in May 2014. See Tr. 143. During

the hearing, Respondent's counsel also represented without objection that Petitioner was paid TTD benefits for the period from May 12, 2014 through September 21, 2014. Tr. 83.

As noted in the circuit court order and the arbitration decision, Petitioner's second exposure date is October 8, 2014. Records from St. Elizabeth's Hospital in Belleview, Illinois, also indicate that Petitioner was admitted on October 8, 2014 after being exposed to fumes at work. Petitioner was discharged the next day with the additional instruction that Petitioner "[m]ay not return to work till cleared by your pulmonologist." PX2. On October 17, 2014, Petitioner returned to Dr. Tuteur, who noted that a treatment plan of bronchodilator medication and environmental control was initiated and generally worked well. Dr. Tuteur added that on the basis of that success and prior records indicating asthma (which Dr. Tuteur noted Petitioner denied), Petitioner was required to return to work and suffered an acute exacerbation from a natural gas leak on his 10th day of work, requiring emergency treatment and overnight hospitalization. The doctor concluded that it was specifically and unequivocally medically contraindicated for Petitioner to return to his work environment. PX3. A confidential medical information form bearing Respondent's logo, signed by Dr. Tuteur and dated October 27, 2014, expressly stated that Petitioner was not released to work. PX3. On January 26, 2015, Dr. Tuteur testified by deposition that in October 2014, he tried to convince Petitioner that not only should Petitioner not work in his current workplace, but also not engage in any remunerative activity in any position where even from time to time he may be exposed to irritants that induce bronchial reactivity. PX8, Tr. 16. Petitioner testified that Dr. Tuteur took him off work again after the second exposure and never returned him to work. Tr. 102, 104.

Petitioner also testified that Dr. Roth never returned him to work. Tr. 104-05. On July 27, 2016, Dr. Roth testified by deposition that she last saw Petitioner on October 28, 2015. PX9, Tr. 48. Dr. Roth's testimony does not indicate that she ever released Petitioner to work.

On March 31, 2017, Petitioner was seen by Dr. Anderson at the Washington University School of Medicine for follow-up treatment of his lung disease and for updated documentation regarding his inability to work. Following an examination, Dr. Anderson's assessments were of: (1) chemically-induced bronchial reactivity; (2) COPD-chronic bronchitis phenotype; and (3) worsening shortness of breath and hypoxemia. Dr. Anderson provided a prescription stating that it was unsafe for Petitioner to return to work at that time. The doctor's recommendations included qualifying Petitioner for oxygen. PX1. Dr. Anderson's treatment note for July 17, 2017 indicates that Petitioner had begun receiving supplemental oxygen. PX1. The doctor's note for November 29, 2017 indicates that Dr. Anderson recommended a portable concentrator due to Petitioner's difficulty with mobility with the oxygen tanks. PX1.

Petitioner additionally testified that Dr. Anne-Marie Puricelli stated that Petitioner should not return to work. Tr. 105. In her March 30, 2015 report, Dr. Puricelli opined "at the present time that [Petitioner] is not capable of performing his normal duties as a Gas Journeyman Leadman." PX4. In her April 18, 2017 report, Dr. Puricelli opined that Petitioner was "currently disabled for all occupations." PX4.

According to Petitioner, Dr. Thomas Hyers was the only doctor who ever told him to return to work. Tr. 105. On September 9, 2014, Petitioner underwent a Section 12 examination by Dr.

Hyers at Respondent's request. Dr. Hyers opined that Petitioner suffered from pre-existing asthma and that the diagnosis of irritant-induced asthma was incorrect. He additionally opined that Petitioner's prior work capability returned on September 19, 2013. RX1, Ex2. Dr. Hyers conducted a second Section 12 examination on December 8, 2014. The only copy of the second report in the record, attached to the second deposition obtained from Dr. Hyers, is incomplete and does not directly address Petitioner returning to work. RX2, Ex1. The testimony provided by Dr. Hyers in his second deposition also fails to directly address the question of when or whether Petitioner was able to return to work. RX2. However, Dr. Hyers did not change his basic medical opinions in his deposition or a February 4, 2015 addendum written after Dr. Hyers reviewed Dr. Tuteur's deposition testimony. RX2, Ex. 2. The strongest inference that could be drawn in Respondent's favor would be that the opinions expressed by Dr. Hyers would suggest that Petitioner similarly would have returned to his baseline work capacity relatively shortly after his second exposure.

As the above findings indicate, Petitioner's testimony regarding temporary total disability is generally corroborated by his treatment records. The opinion from Dr. Hyers regarding Petitioner's ability to return to work is contradicted by the opinions of Dr. Tuteur and Dr. Puricelli. Moreover, the circuit court expressly rejected the conclusion that Petitioner suffered only two temporary aggravations of asthma from the work-related exposures as Dr. Hyers had opined. It is also clear that Petitioner's claimed October 5, 2015 starting date for the second period of disability is incorrect in light of the October 8, 2014 exposure date and subsequent hospital treatment. Given this record, including the relevant findings on the issue contained in the arbitration decision and the circuit court order, Petitioner has proven that he was unable to work for the periods from May 12, 2014 through September 21, 2014 and from October 9, 2014 through the hearing date of June 26, 2018, at a rate of $1,331.20 per week. The Commission also reaffirms the $18,954.97 credit the Arbitrator awarded to Respondent for TTD benefits already paid, due to Petitioner's failure to raise the issue in his Petition for Review or in his statement of exceptions on review.

C. Permanent Total Disability

Lastly, the Commission addresses Petitioner's claim of permanent total disability (PTD). An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Comm'n*, 77 Ill. 2d 482, 487 (1979). A claimant can establish entitlement to permanent total disability benefits under the Act in one of three ways: by a preponderance of the medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of age, training, education, experience, and condition, there are no available jobs for a person in claimant's circumstance. *Federal Marine Terminals Inc. v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 1117, 1129 (2007). When an older employee with few job skills or little education is precluded from returning to the type of employment that comprises the bulk of his or her job history, the employee may qualify for permanent total disability benefits. *Baker v. Chicago Park District,* Ill. Workers' Comp. Comm'n, No. 01 WC 70588, 8 IWCC 287 (Mar. 11, 2008) (citing *E.R. Moore Co. v. Industrial Comm'n*, 71 Ill. 2d 353, 364 (1978)).

As noted earlier, Dr. Tuteur testified that after the second exposure, he tried to convince Petitioner that not only should Petitioner not work in his current workplace, but also not engage in

any remunerative activity in any position where even from time to time he may be exposed to irritants that induce bronchial reactivity. Dr. Tuteur added that there were very few workplaces where that may not occur. He stated that perfumes, colognes, hairspray, and toner, can cause bronchial reactivity in any office. As an example, the doctor testified that Petitioner could not sell shoes, because customers might come in with perfumes or colognes. PX8, Tr. 16. Dr. Tuteur further testified that any episode of exacerbation subjects Petitioner to a remodeling of the airways, scarring which produces irreversible narrowing. PX8, Tr. 17. The doctor's prognosis was that Petitioner's condition is permanent and irreversible. PX8, Tr. 30. On cross-examination, Dr. Tuteur testified that he did not believe Petitioner should stay at home 24/7 for the rest of his life. PX8, Tr. 40. The doctor opined that for total global health, including Petitioner's self-worth as the primary provider for his family, some form of remunerative activity should be attempted, so long as it was safe from a pulmonary standpoint. PX8, Tr. 40-41. However, Dr. Tuteur gave as an example a home workplace environment in which the ventilation and exposure to chemicals like ammonia and bleach can be controlled. PX8, Tr. 40-41.

In her July 27, 2016 deposition, Dr. Roth testified that she could not state with any certainty what Petitioner's current condition was. PX9, Tr. 49.

In his November 24, 2014 deposition, Dr. Hyers opined that Petitioner did not suffer any permanent impairment as a result of the September 4, 2013 exposure. RX1, Tr. 24. In his March 18, 2015 deposition, Dr. Hyers opined that Petitioner did not suffer any permanent partial disability from the September 4, 2013 exposure or the October 8, 2014 exposure. RX2, Tr. 13.

Dr. Puricelli examined Petitioner twice on behalf of Respondent's employee benefits department. In her March 30, 2015 report, Dr. Puricelli opined "at the present time that [Petitioner] is not capable of performing his normal duties as a Gas Journeyman Leadman." PX4. In her second report, dated April 18, 2017, Dr. Puricelli reviewed Petitioner's treatment records and Mr. Dolan's July 29, 2015 vocational assessment. Dr. Puricelli also conducted a physical examination. Dr. Puricelli diagnosed Petitioner with a history of reactive airways disease. As noted earlier, she opined that Petitioner was "currently disabled for all occupations." PX4.

Petitioner submitted a July 29, 2015 vocational and rehabilitation assessment from J. Stephen Dolan, a Certified Rehabilitation Counselor. Mr. Dolan summarized Petitioner's background information, educational history, work history, medical history, functional limitations, and daily activities. Mr. Dolan also administered the Wide Range Achievement Test (WRAT), a standardized test of the abilities to read, spell, and do math. Mr. Dolan found that Petitioner, then 63 years old, read at the 21st percentile, spelled at the 16th percentile, and did math at the 50th percentile compared to others in the 55-64 age range. He concluded that Petitioner knew how to safely and efficiently work around gas and operate heavy machinery. He also concluded that the restrictions from Dr. Tuteur eliminated any job that Petitioner would otherwise be qualified to do. PX7. Petitioner also submitted a May 16, 2017 addendum from Mr. Dolan, who reviewed Dr. Anderson's March 31, 2017 treatment note, a list of Petitioner's essential job functions, and additional records from Dr. Tuteur. Mr. Dolan observed that the records documented that Petitioner's condition was worsening. He concluded that the additional material supported his earlier opinion that Petitioner's need for excessive environmental control eliminated any employment for which Petitioner would be otherwise qualified. PX7.

Respondent submitted a January 29, 2016 vocational assessment from June Blaine, a Certified Rehabilitation Counselor. Ms. Blaine summarized the opinions of Dr. Tuteur, and Dr. Hyers, as well as the initial opinion of Dr. Puricelli. She also summarized Petitioner's educational background, work history, and daily activities. Ms. Blaine administered the WRAT, finding that Petitioner scored at grade level 11.4 in word reading, grade level 9.2 in sentence comprehension, and above grade level 12.9 in math competition. She noted Dr. Tuteur's opinion that work was medically contraindicated precluded her from making vocational planning recommendations, but indicated that relying on Dr. Hyers and Dr. Puricelli allowed her to explore work options other than his current job. Ms. Blaine opined that she needed to clarify whether an alternative position with Respondent might be available. She also opined that Petitioner could acquire computer skills, such as through the Goodwill Community Foundation. She further opined that any alternate employment would have to allow him to work in a more protected environment, in a small company or independent setting during hours where other staff or personnel would be minimal, or work from home. Ms. Blaine added that with additional computer training, Petitioner could pursue positions in clerking, dispatch, and data collection, with entry-level pay of $8.25 to $9.00 per hour. RX3.

Petitioner testified that he sought work with Respondent after the second exposure but was not offered a position. Tr. 105-06. He also stated that he received no education, training, or employment assistance from Ms. Blaine. Tr. 107. Petitioner further testified that Mr. Dolan's recitation of his daily activities and limitations was accurate at the time and remained accurate. Tr. 115-16. He confirmed that the testimony from his wife and Corey Dolan (summarized in the circuit court's order) regarding his condition before and after the exposures was accurate. Tr. 115.

Petitioner submitted a job log documenting his efforts to find alternate employment between August 21, 2016 and January 23, 2017. PX10. He agreed that the vast majority of the employers he contacted were not hiring. Tr. 150. He testified that he had received Social Security Disability benefits in early 2017, but was not currently receiving those benefits. Tr. 152-53. The reports from Mr. Dolan and Ms. Blaine indicate that the benefits had been denied but that Petitioner continued to pursue them. PX7, RX3. Petitioner further testified that he had visited the "Illinois Department of Vocational Rehabilitation" to see whether he could receive assistance in finding employment. Tr. 162. Petitioner received a notification from the Illinois Department of Human Services – Division of Rehabilitation Services (DRS) that his file was to be closed on November 16, 2016 based on a determination that Petitioner's illness was too significant for him to obtain employment at that time. The notice also stated that Petitioner was free to return to DRS if his disability somehow improved. PX11.

Based on the totality of the evidence in the record, Petitioner has proven PTD by a preponderance of the medical and vocational evidence. Dr. Tuteur testified that Petitioner should not work in any position where even from time to time he may be exposed to irritants that induce bronchial reactivity. Although Dr. Tuteur suggested that some sort of home employment might be possible, Mr. Dolan concluded that the restrictions from Dr. Tuteur eliminated any job that Petitioner would otherwise be qualified to do. Ms. Blaine opined that with additional computer training, Petitioner could pursue positions in clerking, dispatch, and data collection, but Petitioner was never afforded any training. Moreover, Ms. Blaine's opinion was based in part on Dr.

Puricelli's initial opinion that Petitioner could not perform his old job. Dr. Puricelli, who examined Petitioner twice at Respondent's request, ultimately opined that Petitioner was currently disabled for all occupations. Dr. Hyers opined that Petitioner did not suffer any permanent partial disability from the two exposures, but that opinion is based on the diagnosis that Petitioner only suffered temporary exacerbations of pre-existing asthma. The circuit court ruled that the conclusion that Petitioner only suffered temporary exacerbations and that the asthma simultaneously and independently progressed from symptoms that never required treatment or loss of work time to symptoms so severe that Petitioner requires oxygen and has an altered voice cannot be supported on this record.

In addition, the medical opinions regarding PTD are corroborated by the remaining evidence on the issue. Petitioner conducted an ineffectual job search, which is not surprising given his age, experience, and lack of assistance from Respondent or Ms. Blaine. Our state's DRS determined that Petitioner's illness was too significant for him to obtain employment and there is no evidence that this determination has changed. Accordingly, considering the record as a whole, the Commission concludes that the Petitioner has proven by a preponderance of the credible evidence that he is permanently and totally disabled pursuant section 8(f) of the Act, beginning June 26, 2018 at a rate of $1,331.20 per week.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's condition of ill-being at the time of the arbitration hearing was causally connected to his work accidents on September 4, 2013 and October 8, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $47,973.55 to the medical providers as stated in Petitioner's Group Exhibit 6, pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given a $84,415.61 credit for group 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 the sum of $1,331.20 per week for a period of 212 and 6/7ths weeks, from May 12, 2014 through September 21, 2014 and from October 9, 2014 through the hearing date of June 26, 2018, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive a credit of $18,954.97 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner permanent and total disability benefits of $1,331.20 per week for life, commencing June 27, 2018 as provided in §8(f) of the Act.

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

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

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.

April 12, 2022

d: 04/07/22
CMD/kcb
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

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

22IWCC0137

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNCAN, RICKY A
Employee/Petitioner

Case# **13WC031742**
17WC027834

AMEREN IL
Employer/Respondent

On 8/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0384 NELSON & NELSON
DAVID NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62220

1241 LEMP &MURPHY PC
DONALD MURPHY
8045 BIG BEND BLVD STE 202
WEBSTER GROVES, MO 63119

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

- [ ] 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

Ricky Duncan
Employee/Petitioner

v.

Ameren, IL
Employer/Respondent

Case # 13 WC 031742

Consolidated cases: 17-WC-027834

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **Tuesday, June 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **09/04/13 and 10/08/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$103,833.60**; the average weekly wage was **$1,996.80**.

On the date of accident, Petitioner was **61/62** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of **$18,954.97** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$18,954.97**.

Respondent is entitled to a credit of **$84,415.61** under Section 8(j) of the Act.

ORDER

THE ARBITRATOR DENIES PPD BENEFITS AND ANY ADDITIONAL TTD OR MEDICAL BENEFITS. SEE ATTACHED.

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

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

Signature of Arbitrator

8/11/18
Date

AUG 14 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

☐ 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

Ricky Duncan
Employee/Petitioner

v.

Ameren, IL
Employer/Respondent

Case # 13 WC 031742

Consolidated cases: 17-WC-027834

STATEMENT OF FACTS

I. Testimony at Trial

The initial witness was Annette Duncan, wife of Petitioner, Ricky Duncan. At the time of trial, they had been married 43 years. She testified that prior to the initial exposure on 09/04/13 he had no trouble breathing, no coughing, wheezing, or the like. Further, that he was not taking any types of medication, such as Albuterol inhaler or steroids. (Tr. 13-15).

Annette Duncan did testify that there were three occasions of breathing symptoms prior to the exposure on 09/04/13, which she described as episodes of bronchitis and pneumonia. (Tr. 15).

Annette Duncan testified that prior to 09/04/13 her husband had no issues with doing work around the house, taking vacations, burning leaves, exposure to detergents or cleaning items around the house. (Tr. 18-20).

Annette Duncan testified that between the initial exposure on 09/04/13 and the subsequent exposure on 10/08/14 her husband did not want to leave the house, was concerned he would have attacks and was depressed. (Tr. 23-24).

There was discussion as to surveillance which was undertaken following the initial exposure (on 08/30/14), which Annette Duncan had reviewed. This involved a charity event at an Elks Lodge, to which both she and her husband belong. She admitted this showed her husband near a BBQ grill, allegedly though away from the smoke. (Tr. 21-23).

Allegedly after the exposures, Annette Duncan started changing filters in the house, removing soap powders, deodorants, lotions, or similar items, to avoid her husband having any triggers. (Tr. 26-29).

Allegedly after the two exposures, Petitioner's symptoms never returned to baseline, getting worse. (Tr. 33-34).

On cross-examination, Annette Duncan testified she was aware that her husband was seeing Dr. Roth at Illini Family Medicine prior to both exposures. Further, that prior to both exposures, he had been prescribed Flonase, Addair (an inhaler), the latter allegedly given with pneumonia, statements as to wheezing, statements as to possibility of asthma, prescriptions of Biaxin and Albuterol. (Tr. 36-38).

Annette Duncan was not aware that on 01/28/13, prior to the initial or either exposure, Dr. Roth had diagnosed her husband with asthma. Further, that there was reference by Dr. Roth to her husband having a frequency of asthma attacks about once a year. Finally, that on 08/24/13, two weeks prior to the initial exposure, her husband was reporting fatigue and difficulty sleeping. (Tr. 38-41).

The second witness at trial was Corey Duncan, Petitioner's son. Both have been employed over the years at Ameren as gas journeymen. He was not present at the initial exposure on 09/04/13. However, he did testify as to growing up with his father, going hunting, shooting guns, wearing cologne with no issues, his father not having any reactions to orders, perfumes or the like. (Tr. 49-51). However, that after the second exposure, he would cough excessively, wheeze and the like. (Tr. 51-52).

Prior to the exposures, Corey Duncan testified that his father and he would go to drag races, where they would be exposure to fluids and fumes. However, that after the exposures, they have not been able to do so. (Tr. 53-55).

Corey Duncan testified that when his father visits (after the exposure) he has to make sure there are no cleaners, "smelly stuff", perfumes or the like, for fear of reaction. (Tr. 62-63). Further, that he had no such problems prior to the exposure. (Tr. 63-64).

On cross-examination, Corey Duncan confirmed he was not aware of any emergency room visits involving his father in terms of pulmonary problems other than on the exposure of 09/04/13 and 10/08/14. Further that after the exposures, his father would wear a mask when it was cold but that in terms of smells, but that the mask "didn't really block a whole lot out". (Tr. 65-66).

The third witness was Petitioner, Ricky Duncan. At trial, he was 66 years old. He testified his voice was different, because of having walked into the building where the trial took place. (Tr. 69-70).

There was a discussion as to the initial exposure on 09/04/13, when Petitioner and another employee were cutting a four inch cast iron line. Water came out, then some type of liquid. It emptied into a nearby ditch, and it was noticed the water was turning red and foamy. (Tr. 70-72).

Allegedly after this exposure, Petitioner had a tight chest, with difficulty breathing. He called his supervisor, who took him to the emergency room. (Tr. 74).

At the time of trial, Petitioner testified he was using an inhaler every four to six hours as needed, or if he would be involved with triggers. He was also carrying oxygen. On the date of trial, he had already used one bottle of oxygen, greater than usual. (Tr. 79-80).

Petitioner talked about various triggers, including paint, perfumes and the like. (Tr. 81).

Petitioner only missed a couple of days off work after the initial exposure. He did not begin missing time from work until 05/12/14, approximately seven months thereafter. He was paid TTD from 05/12/14 through 09/21/14. He then returned to work on 09/22/14. (Tr. 83-84).

Following the return to work on 09/22/14, there was the subsequent exposure on 10/08/14. Petitioner was in the crew room, when he smelled a very strong order of gas. He stated there was limited ventilation, and he again experienced chest pain and difficulty breathing (Tr. 88-90). He was taken by ambulance to the hospital. He was admitted overnight and then discharged the second day. (Tr. 92-93).

After the subsequent exposure, Petitioner returned to Dr. Tuteur, who authorized lost time. (Tr. 101-102). Since then, Dr. Tuteur never released Petitioner back to work. (Tr. 104).

Petitioner testified as to a job search log with approximately 500 contacts, further his evaluation with a vocational specialist, June Blaine (at the request of Respondent) and with Stephen Dolan (at the request of his attorney). There has been no vocational rehabilitation effort. (Tr. 107-108).

On cross-examination, there was a discretion with Petitioner as to his extensive prior treatment with Dr. Roth. That began in October of 1998 with a history of trouble breathing and chest pain. Then in July of 1999, shortness of breath and a referral to Dr. West for pulmonary function testing. Petitioner did not remember Dr. West suggesting obstructive airways disease as far back as August of 1999. Nor did he remember Dr. West talking about the possibility of a work up for asthma. Petitioner testified to knowledge, he was never diagnosed with asthma. (Tr. 129-131).

There was discussion as to excessive fatigue in May of 2001, shortness of breath and coughing in December of 2001, bronchospasm and being prescribed an Albuterol inhaler in June of 2003, prescribed Flonase in October of 2004, Advair in November of 2005, wheezing and a prescription of Biaxin and Albuterol in February of 2009, chest tightness and wheezing in May of 2001. (Tr. 131-135).

Petitioner was confronted with a history from Dr. Roth on 01/23/13, approximately 7 ½ months prior to the initial exposure of 09/04/13, referencing asthma. Petitioner again stated he was not diagnosed with asthma. Further, that he did not understand the discussion as to frequency of attacks as being approximately once a year, as reflected in the records from Dr. Roth. (Tr. 136-137).

Petitioner indicated that the co-employee who was with him at the time of the initial exposure on 09/04/13 was Al Hoernis. Mr. Horenis and Petitioner were in the same spot when the material came out. They both cut their pipe. Petitioner did not know whether Mr. Horenis had any symptoms with this exposure or had any treatment. (Tr. 140-141).

Petitioner admitted returning to work a couple of days after the initial exposure on 09/04/13 until being taken off again in May of 2014, approximately eight months. During that time frame, he was a gas journeyman lead man, and would work in the field. He did try to control his environment during that time frame. (Tr. 142-143).

There was a discussion as to the surveillance and BBQ at the Elks Lodge on 08/30/14. Petitioner had reviewed the video. He admitted to being in the vicinity of the BBQ and fumes, also an individual smoking a cigarette. However, allegedly that he was upwind. (Tr. 143-144).

Petitioner admitted that after the initial exposure on 09/04/13 and the return to work a couple of days after, he did not wear a mask during that time frame, up until the subsequent exposure on 10/08/14. (Tr. 154). Further, that thereafter, he would wear the mask only if it was cold or if there was dust flying. As of the date of trial, he was no longer wearing the mask, being on oxygen. (Tr. 155).

Petitioner was never prescribed the mask, rather he just went to the store to buy a mask. He admitted that the masks identified on surveillance did not hold back fumes. (Tr. 156).

Petitioner testified that other than an emergency room for a bee sting, there have been no emergency room visits since 10/08/14. Specifically, no emergency room visits thereafter based on breathing or lung issues. (Tr. 157-158).

As of the trial date, Petitioner still had group insurance through Ameren, with that policy honoring treatment relating to pulmonary issues. (Tr. 160).

As to the job search log, Petitioner admitted that the vast majority, 90% to 95% indicated the employers were not hiring or no jobs were open. (Tr. 150).

II. Medical Records and Deposition Testimony of Dr. Roth

Dr. Roth is Petitioner's family physician, and has been since the late 1990's. She discussed Petitioner's pulmonary symptoms over the years, including after the two exposures. It was her opinion that "I do not think he has returned to baseline after those exposures." (Tr. 31).

On cross-examination, there was a discussion as to Petitioner's history of pulmonary or arguably asthma, dating back to 1999. She admitted that as far back on 07/28/99 she referred Petitioner to Dr. West, with a history of shortness of breath on exertion. (Tr. 34). Further, that his oxygen level that date was 68, whereas she would usually "like to see them between 80 and 100". Thus, that the oxygen level as of that date was below normal. (Tr. 35). Dr. Roth admitted that on 08/08/99 there was a discussion as to potential obstructive airways disease. Further, that

in August of 1999 there was a statement as to the possibility of a diagnosis of asthma. (Tr. 35-36).

Dr. Roth prescribed Albuterol on 06/18/03, designed to open up the airways and relax the spasm in the airways. She admitted an Albuterol inhaler is sometimes prescribed for asthma. (Tr. 41).

On 11/23/05 Dr. Roth prescribed Advair 250/50. (Tr. 41-42).

On 02/16/09 there was reference to Petitioner having reported wheezing, with a questionable history of asthma. (Tr. 42-43).

Dr. Roth admitted that as far back as February of 2009 there was concern as to a potential diagnosis of asthma. Further, that wheezing would be consistent with a diagnosis of asthma. Finally, noting that as of 01/23/13 there was a specific discussion as to "asthma first diagnosed in adulthood . . . to be conceived as attacks once per year". (Tr. 43-44).

There was a visit on 08/15/13, less than a month prior to the initial claimed exposure. Therein, reference to the Petitioner having fatigue for the last five years or so. (Tr. 44-45).

III. Medical Records and Deposition Testimony of Dr. Tuteur

Dr. Tuteur initially saw Petitioner on 11/06/13. He noted the Petitioner had never smoked cigarettes. Further, with a history of pneumonia and chest discomfort over the years. He also made reference to the prior evaluation with Dr. West "which is the only date I have", with reference to the possibility of asthma dating back to 2002. (Tr. 8-10).

Dr. Tuteur had a history of the Petitioner cutting a pipe, with exposure to materials thereafter. He talked about the return to work in May of 2014, recommending environmental control. He then discussed the subsequent exposure on 10/08/14. (Tr. 12-16).

Dr. Tuteur talked about every exposure being an exacerbation, involving remodeling of the airways. Further, that this would be irreversible. (Tr. 17).

In discussing references to the possibility of pre-existing asthma or asthma in general, Dr. Tuteur advised "I view use of the term asthma – and I will give you an anecdote that will explain this – as very much of the concept of the blind man – the multiple blind men assessing the camel". He then went into his view as to why only specialists such as he had would be qualified to make or discuss the diagnoses. (Tr. 24-26).

Dr. Tuteur testified that the exposures on 09/04/13 and 10/08/14 made Petitioner worse, that he would not get better, that condition would be permanent and irreversible. (Tr. 28-30).

As of the date of his deposition on 01/26/15, Dr. Tuteur admitted that he last seen the Petitioner in October of 2014. (Tr. 35). He admitted that there is no way he could testify as to what Petitioner had been doing since October of 2014, since he had not seen him since then.

Dr. Tuteur did admit on cross-examination that "not everybody gets remodeling every time you have an exacerbation". Further, that pulmonary function can remain the same. Further, that that would be no way to objectively indicate whether there had in fact been remodeling. (Tr. 36-37).

Dr. Tuteur indicated that he knew Dr. Hyers in a professional capacity. Further, that he had no reason to question his integrity or qualifications as a pulmonary specialist. (Tr. 38).

As to the degree of disability, Dr. Tuteur admitted that he did not recommend Petitioner be home bound and not capable of going to any type of work environment. Further, "I strongly feel that for total global health, for persons with this condition, that some form of remunerative activity, as long as it is safe from a pulmonary stand point should be attempted". He then discussed the possibility of a work place home environment, environmental control, ventilation, etc. (Tr. 40-41).

In discussing potential irritants, such as perfume, Dr. Tuteur admitted that there was no evidence in the record as to Petitioner needing to seek additional treatment when he was allegedly exposure to any such triggers. (Tr. 46).

IV. IME Reports and Deposition Testimony of Dr. Hyers

Dr. Hyers is a board certified pulmonary specialist, who took an initial evaluation of Petitioner on 09/09/13. His diagnosis was asthma. He indicated that if the exposure on 09/04/13 in any way impacted the asthma, it was transient. He noted that the acute problems seem to have resolved by the time of a follow up with Dr. Roth at Illini Family Medicine within a couple of weeks thereafter. He did not feel Petitioner had sustained any permanent impairment as a result of the industrial exposure on 09/04/13.

An initial deposition of Dr. Hyers took place on 11/24/14. Therein, he reiterated his findings and conclusions that Petitioner had an acute exposure on 09/04/13, but had returned to baseline within several weeks thereafter, as documented in a follow up visit to Dr. Roth at Illini Family Medicine.

On cross-examination, Dr. Hyers noted Petitioner had a history of wheezing for 10 to 12 years prior to the exposure on 09/04/13. (Tr. 25-26). He disagreed with Dr. Tuteur as to the diagnosis of irritant induced asthma. He stated this diagnoses would be based on somebody who developed asthma without a prior history, noting Petitioner had a prior history of asthma. (Tr. 27).

Dr. Hyers went into background in terms of diagnosed asthma. He stated it is consistent with shortness of breath, chest tightness, coughing and wheezing here with a stethoscope. (Tr. 29). He also noted spirometry testing, though he was not aware Petitioner had any such testing prior to the initial exposure on 09/04/13. (Tr. 29).

Dr. Hyers noted the 01/21/13 report from Dr. Roth (prior to the initial exposure) with reference to medical problems to be addressed that date, including asthma. (Tr. 34).

Dr. Hyers also noted reference to a diagnosis of asthma as far back as to 02/16/09, including recurrent wheezing and cough. (Tr. 35).

In discussing references in Dr. Roth's records and diagnosis of bronchitis, Dr. Hyers noted that it is often a substitute from a general practitioner or non-specialist for asthma. (Tr. 43-44). Dr. Hyers admitted Petitioner would be susceptible to flare-ups of asthma, and medical treatment relating thereto. (Tr. 56).

Dr. Hyers testified that a prescription for Addair is typically for asthma or COPD – with no indication Petitioner had COPD. Further, that this was prescribed as far back as 11/23/05. (Tr. 64).

Dr. Hyers' initial deposition on 11/24/14 was soon after the subsequent exposure on 10/08/14, and he did not have sufficient information to reply to the impact of that event.

Thus, there was a second evaluation with Dr. Hyers on 12/08/14. That incorporated a history of the subsequent event on 10/08/14 and treatment with Dr. Tuteur thereafter. Dr. Hyers reiterated his previous opinion that Petitioner did not suffer from irritant induced asthma or irritant induced bronchoreactivity; rather, noting a history of asthma dating back over 10 years. He did not feel any exposure at Ameren would increase the risk of asthma attack more than any exposure away from the work place. He advised Petitioner had no permanent partial disability as the result of the exposures on 09/04/13 and/or 10/08/14. Further, that he did agree with Dr. Tuteur that Petitioner should take common sense precautions to avoid and mitigate exposure to fumes, smokes, molds, sense and other irritants, "this is advice that is appropriate for all asthmatics".

Dr. Hyers' supplemental deposition took place on 03/18/15.

Dr. Hyers testified that the subsequent visit on 12/08/14 there was an attempt at another spirometry. However, that Petitioner did not give a reproducible effort. He thought that was based on lack of effort. (Tr. 11). He noted everything else was normal with regard to the evaluation on 12/08/14, specifically, that Petitioner was in no distress, lung exam was normal, he moved about the office normally. (Tr. 11).

Dr. Hyers noted the Petitioner had pre-existing asthma, dating ten years prior to any claimed exposure at Ameren. He did not feel that any exposure at Ameren would be any more risky than his moving about in the general environment. He did not believe that Petitioner sustained any permanent partial disability as the result of either the exposure on 09/04/13 or 10/08/14. (Tr. 12-13).

Dr. Hyers noted that after the initial exposure of 09/04/13 and a visit at Dr. Roth/Illini Family Medicine a week or two later the findings had returned to baseline. Similarly, after the subsequent exposure on 10/08/14 and a return to Dr. Tuteur, within a couple of weeks, the findings had returned to baseline. (Tr. 16).

V. Surveillance

Surveillance on 08/30/14 revealed Petitioner to be in the area of a BBQ, also an individual smoking, with no apparent distress. He was able to move some bicycles out of the back of a pickup truck.

Subsequent surveillance over many years revealed Petitioner sometimes wearing a mask around at a gas station, sometimes not wearing a mask.

VI. Martin Upchurch/SEA Limited.

Mr. Upchurch is an engineer. He reviewed surveillance, identifying the different types of masks Petitioner was earning over the years. It is was his opinion that neither would have been protective of gas fumes or related odors.

VII. Vocational Assessment of June Blaine

June Blaine testified regardless of the causation, he was restricted in his job opportunities. She indicated that he would be employable, but at a reduced earnings, in the range of $10.00 to $12.00 per hour.

VIII. Stephen Dolan

Mr. Dolan examined the Petitioner at the request of his attorney. It was Mr. Dolan's opinion that Petitioner would be permanency and totally disabled as the result of his pulmonary condition.

FINDINGS OF FACT

It is found Petitioner has symptoms comparable with the diagnosis of asthma dating back to the late 1990's. Further, that there was several specific references to a potential diagnoses of asthma, along with inhaler prescribed on different dates prior to the exposures on 09/04/13 and 10/05/14.

At a follow up with Dr. Roth on 09/09/13 there was a reference to the exposure on 09/04/13, with acute symptoms.

At a follow up with Dr. Roth on 09/19/13 there was an essentially negative evaluation. On that date, diagnoses were cough and acute sinusitis. Petitioner was advised to avoid cigarette smoke.

At a time when Petitioner was claiming reactivity to different exposures and problems with exposures at work, surveillance revealed that he was capable of being outdoors, in the vicinity of a BBQ, in the vicinity of an individual smoking cigarettes, able to engage in exertional activity, all without apparent distress.

There was a subsequent exposure on 10/08/14. There was no objective testimony from Dr. Tuteur or otherwise as to Petitioner's clinical findings or symptoms having materially changed thereafter.

Dr. Tuteur did not have all records from Dr. Roth/Illini Family Medicine. Nevertheless he refuted any diagnosis of asthma prior to the 09/04/13 and 10/08/14, suggesting only a pulmonary specialist such as he would be capable of making that diagnoses.

Dr. Hyers evaluated Petitioner on two occasions, one after the initial exposure, and one after the subsequent exposure. He did review the records from Dr. Roth/Illini Family Medicine. He documented references to diagnosis of asthma and medications (Advair and Albuterol) prior to either exposure that would be consistent with a diagnosis of asthma.

Dr. Hyers testified credibly that shortly after both exposures, Petitioner's symptoms abated, at least with regard to objective findings.

Dr. Hyers did not dispute that Petitioner, having asthma, would be susceptible to further aggravations, as would be the case will all asthmatics. However, he did not feel that either exposure of 09/04/13 and 10/08/14 resulted in any permanent impact on Petitioner's underlying asthma.

It is found that Dr. Hyers' testimony is more compelling than that from Dr. Tuteur, given that Dr. Hyers had all relevant documentation and testified accordingly as to Petitioner's pre-existing asthma and symptoms in accord therewith; further with Dr. Hyers noting after both exposures, a relevantly prompt return to similar objective findings.

CONCLUSIONS OF LAW

It is found Petitioner sustained temporary aggravations of his pre-existing asthma via the exposures on 09/04/13 and 10/08/14.

It is noted at trial that Petitioner testified as to significant and permanent exacerbations after the initial exposure of 09/04/13 and the subsequent exposure of 10/08/14. However, his credibility is undermined by the fact that after what was alleged to the most significant event on 09/04/13, he returned to work within a couple of days thereafter. Further, at a time when he was claiming significant and unabated symptoms, he was found on surveillance to be quite active outdoors, exposed to multiple fumes, without any evident of impairment or difficulty relating thereto.

It is not disputed Petitioner has a significant condition of asthma. In fact, that is documented by references to asthma and symptoms compatible to asthma for more than 10 years prior to either claimed exposure.

Petitioner has the burden of proof on all issues, including medical causation.

It is found that Petitioner has only sustained his burden of proof in determining that there was a temporary aggregation of underlying asthma as the result of the exposures on 09/04/13 and 10/08/14; failing to meet his burden of proof as to any indication of permanent aggravation or permanent partial disability relating thereto in terms of the underlying asthma – rather, that any perceived progression of symptoms would be compatible with his ten plus year history of symptoms compatible with asthma.

All other issues are rendered moot.

IN THE CIRCUIT COURT
TWENTIETH JUDICIAL CIRCUIT
ST. CLAIR COUNTY, ILLINOIS

RICKY A. DUNCAN,)
)
Plaintiff/Petitioner,)
) Case No.: 19-MR-199
v.)
)
ILLINOIS WORKERS' COMPENSATION)
COMMISSION and AMEREN ILLINOIS,)
)
Defendants/Respondents.)

ORDER

This cause coming before the Court; the Court, being fully advised in the premises and having jurisdiction over the subject matter, finds the following:

This case involves two claims that were consolidated for trial. Each claim involves an exposure to Petitioner's lungs. The two dates of injury are September 4, 2013 and October 8, 2014.

Trial took place before an arbitrator in Collinsville on June 26, 2018. Petitioner, Petitioner's wife and Petitioner's son all came to the hearing and testified live. At the hearing, the parties submitted deposition testimony of three doctors – Petitioner's treating doctors, Tuteur and Roth, and also Respondent's IME, Dr. Hyers.

The Arbitrator concluded that Petitioner failed to prove one element of the case, causal connection, and thus found for the Respondent. Petitioner reviewed (appealed) and the Commission confirmed (affirmed) by adopting the Arbitrator's opinion (and without writing its own opinion).

In the present case, the Commission determined that Petitioner did not establish causal connection by a preponderance of the evidence. For the reasons that follow, the Court finds the

Commission's decision was against the manifest weight of the evidence because the opposite conclusion is clearly apparent to the Court.

Summary of Dr. Tuteur's Deposition

Peter G. Tuteur, M.D. testified on behalf of the Petitioner.

Dr. Tuteur is a pulmonologist. He is an Associate Professor of Medicine at Washington University School of Medicine. According to his CV, he attended Johns Hopkins and then the University of Illinois School of Medicine. He is a member of various professional societies, has consulting relationships and board memberships that are widespread, and has published numerous articles over the years on subjects relating to pulmonology and industrial asthma.

He has a general interest in occupational environmental lung disease.

He first saw the Petitioner on November 6, 2013 at the request of Corporate Claims Management. (P.Ex.8, Page 8).

At that time, Petitioner gave a history that he was installing a gas service, and he cut a four-inch galvanized pipe out of which clear liquid and fumes emanated. In the process, he developed significant pulmonary symptoms of breathlessness, coughing, wheezing, and chest tightness that resulted in an emergency room visit and subsequent hospitalization. (P.Ex.8, Page 10-11).

Prior to September 2013 he did not have a tendency to react in a significant way to the pervasive irritants in our daily lives. (P.Ex.8, Page 12).

There was no plausible etiology other than the September exposure in the workplace to account for the symptoms Petitioner experienced. (P.Ex.8, Page 13).

He had the methacholine challenge test and that was positive. Overall, the clinical examination revealed he had bronchial reactivity. (P.Ex.8, Page 14).

Dr. Tuteur saw Petitioner a second time in November 2013, again at the request of Corporate Claims Management for the specified purpose of assessment of disability. (P.Ex.8, Page 14).

Later Dr. Tuteur saw Petitioner at the request of Dr. Adele Roth. He instituted a plan of Advair. It was suggested that the Petitioner eliminate environmental triggers at work to avoid the bronchial reactivity -- particularly natural gas, diesel exhaust, and other particulate matter and fumes. (P.Ex.8, Page 15).

Dr. Tuteur saw Petitioner again in May 2014. At that time, Petitioner described instances of recurrent exacerbations. The doctor advised him to try more intensive management of his environment. (P.Ex.8, Page 15).

When he was seen again in October 2014, he had recently experienced a short hospitalization in response to an additional exposure in the workplace. The doctor tried to convince him he should not work at that place of employment. (P.Ex.8, Page 16).

Regarding causation, Dr. Tuteur stated that Petitioner suffered an injury when he was exposed to chemicals on the job on September 4, 2013. (P.Ex.8, Page 27).

The injury was an injury to his airways. (P.Ex.8, Page 27).

Most acutely, the injury was inflammation. The subsequent development of serious bronchial reactivity followed as a result. (P.Ex.8, Page 27).

The condition is permanent. (P.Ex.8, Page 28).

In offering that opinion, Dr. Tuteur had the benefit of Respondent's independent testing of the substance to which the Petitioner was exposed. The analyses showed a variety of solvents, including benzene and mercury, to which the Petitioner was exposed. (P.Ex.8, Page 30). These

low-molecular-weight inorganic chemicals are known to initiate the condition from which the Petitioner suffers, according to Dr. Tuteur. (P.Ex.8, Page 30).

The condition is irreversible. (P.Ex.8, Page 30). Dr. Tuteur therefore recommended against work. (P.Ex.8, Page 31).

It is medically contra-indicated, he said, for Petitioner to be exposed to conditions and substances that would trigger exacerbations. (P.Ex.8, Page 31).

Dr. Tuteur described Petitioner's problems as a tendency for the pulmonary "architecture" to remodel with each and every exacerbation. Remodeling is the irreversible component of the disease process. It is scarification due to inflammation. (P.Ex.8, Page 36).

The doctor does not believe that Petitioner should stay in his home twenty-four hours a day, seven days a week for the rest of his life. (P.Ex.8, Page 40). He is able to do any work where he is not at risk of being exposed to triggers that exacerbate his condition. (P.Ex.8, Page 40).

Dr. Tuteur encouraged him to be active, to the extent that he can, because it feeds his sense of worth. (P.Ex.8, Page 41).

From a medical standpoint, however, it is important that Petitioner not be exposed to environmental triggers (P.Ex.8, Page 44), and it is very challenging to control adequately the environment. (P.Ex.8, Page 45).

Dr. Tuteur clarified that Petitioner is not allergic to anything. (P.Ex.8, Page 45). His condition is not an allergic process. (P.Ex.8, Page 45). He has an irritant-induced condition. (P.Ex.8, Page 45).

Summary of Dr. Hyers' Deposition

Respondent engaged Thomas M. Hyers, M.D. as its Section 12 examiner.

Dr. Hyers saw the Petitioner on two occasions. Dr. Hyers wrote three reports. He testified on November 24, 2014 and also on March 18, 2015.

Dr. Hyers is a board-certified pulmonologist. He occasionally testifies in the medical-legal context for plaintiffs and for defendants. His private practice is in St. Louis County, Missouri.

Petitioner gave Dr. Hyers substantially the same history as he gave other medical professionals. (R.Ex.1 at Page 10, Lines 13-25).

Dr. Hyers did not accept the diagnosis by Dr. Tuteur of "irritant-induced bronchial reactivity." Dr. Hyers prefers to use the term irritant-induced asthma for similar conditions – although not Petitioner's. (R.Ex.1 at Page 12).

According to Hyers, the x-rays of Petitioner's lungs did not point to severe asthma or COPD. (R.Ex.1 at Page 15). Dr. Hyers does not believe Petitioner suffers from COPD. (R.Ex.1 at Page 13).

Dr. Hyers attempted to conduct testing known as spirometry, which could confirm the existence of asthma, but he could not validate the test results. (R.Ex.1 at Page 15).

Dr. Hyers attributed the inconclusive test results to a lack of reproducible effort by Petitioner. (R.Ex.1 at Page 18).

According to Dr. Hyers, "His respiratory rate was within the normal range, and he didn't appear to be having any respiratory symptoms. He wasn't coughing. He wasn't showing any evidence of other respiratory problems" during the exam. (R.Ex.1 at Page 19).

Dr. Hyers' diagnosis is asthma. (R.Ex.1 at Page 20).

When asked his opinion as to whether the exposure of September 4, 2013 impacted Petitioner's underlying asthma, Dr. Hyers opined "If it did, it was transient." (R.Ex.1 at Page 21).

Dr. Hyers is confident that Petitioner had an underlying asthmatic condition before the exposure of September 4, 2013. (R.Ex.1 at Page 21).

Dr. Hyers believed that Petitioner suffered no permanent impairment as a result of the exposure. (R.Ex.1 at Page 24).

Dr. Hyers stated that "irritant-induced asthma" – which the Petitioner does not have – is a condition that develops with an exposure ***in the absence of a prior history of asthma***." (R.Ex.1 at Page 27).

He doesn't know what the phrase "irritant-induced bronchial reactivity" means. (R.Ex.1 at Page 28).

Dr. Hyers believes that Petitioner had asthma well prior to the exposure in 2013. Dr. Hyers acknowledged that asthma may be diagnosed on the bases of spirometry. (R.Ex.1 at Page 30).

He does not have knowledge of a prior spirometry test for the Petitioner. (R.Ex.1 at Page 32).

Dr. Hyers stated the clinical signs or symptoms of asthma are "shortness of breath, chest tightness, coughing, and wheezing." (R.Ex.1 at Page 32).

He says typically "when you have all four, that's asthma until proven otherwise." (R.Ex.1 at Page 32).

He went on to say "you don't always have four" symptoms. (R.Ex.1 at Page 36).

According to Dr. Hyers, the Petitioner can get better. In other words, the symptoms can improve. (R.Ex.1 at Page 40).

According to Dr. Hyers, there were numerous instances where the word asthma appears in the records of Dr. Adele Roth, the Petitioner's long-time family doctor, and that is his basis for his opinion that Petitioner had asthma prior to the first exposure. (R.Ex.1 at Page 45).

Dr. Hyers acknowledged that the pulmonologist whom Petitioner had seen on numerous previous occasions for sleep apnea, Dr. Dothager, never diagnosed Petitioner with asthma. (R.Ex.1 at Page 46).

Dr. Hyers conceded that the Petitioner was not on any medications at the time of the exposure in 2014. (R.Ex.1 at Page 53).

Prior to the date of exposure, Petitioner had most recently been seen by Dr. Roth at her office on August 15, 2013. At that time, he was asymptomatic with respect to any pulmonary conditions, including asthma, if he had it. (R.Ex.1 at Page 54).

Dr. Hyers agrees that the St. Elizabeth's hospitalization and treatment was reasonable, necessary and related to the exposure. (R.Ex.1 at Page 56, Lines 1-5). He also believes that Dr. Tuteur's treatment was reasonable and necessary for asthma. (R.Ex.1 at Page 56).

Dr. Hyers stated that Petitioner is susceptible to exacerbations. That would include emergency room visits and even overnight hospitalizations. (R.Ex.1 at Pages 56-57).

The exacerbations could be triggered by workplace exposures. (R.Ex.1 at Page 57).

Dr. Hyers was unaware of, and there is no evidence in the record that the Petitioner had any acute exacerbations (of the presumed asthma) leading to treatment before the September 4, 2013 exposure. (R.Ex.1 at Page 60).

Nonetheless, Dr. Hyers does not believe that the specific exposure in September 2013 made Petitioner more susceptible to subsequent exposures or triggers. (R.Ex.1 at Page 67).

Dr. Hyers' second deposition took place on March 18, 2015, after he saw the Petitioner again on December 8, 2014. He took an interval history that included the Petitioner's second exposure on October 8, 2014. (R.Ex.2 at Page 7).

On the date of Hyers' second exam, Dr. Hyers again attempted to obtain a spirometry test and again found its results were unreliable because, in his opinion, the Petitioner did not give a reproducible effort. (R.Ex.2 at Page 10).

Dr. Hyers was the only medical professional who performed that test without being able to elicit reliable test results. The test was successfully performed at St. Elizabeth's Hospital in Belleville on multiple occasions, by Dr. Tuteur at Washington University on multiple occasions and by Dr. Tuteur's successor, Dr. Anderson, at Washington University on multiple occasions.

Dr. Hyers concluded after the second examination that Petitioner had underlying asthma that pre-existed the first workplace exposure on September 4, 2013. (R.Ex.2 at Page 12). Dr. Hyers stated he did not think Petitioner had irritant-induced asthma in the sense that an exposure on or around September 4, 2013 caused ***the onset*** of Petitioner's asthma. (R.Ex.2 at Page 12).

Dr. Hyers did not believe Petitioner incurred any permanent disability as a result of either of the Petitioner's exposures. (R.Ex.2 at Page 13).

According to Dr. Hyers, because irritant-induced asthma is a diagnosis that, by definition, exists only when the Petitioner or individual had no pre-existing asthma, Petitioner could not have that condition (by definition). (R.Ex.2 at Page 14).

In his deposition testimony, Dr. Hyers stated that there were six or seven notations of pre-existing asthma in Dr. Roth's records (i.e. Illini Family Medicine). (R.Ex.2 at Page 15).

Dr. Hyers does not know what originally caused Petitioner's asthma, but he does not believe Petitioner has irritant-induced asthma in the sense that Dr. Tuteur uses that phrase. (R.Ex.2 at Page 12).

Dr. Hyers reiterated that the only real basis for his opinion that Petitioner had pre-existing asthma is the six or seven notations in the Illini Family Medicine records. (R.Ex.2 at Page 15).

Dr. Hyers stated that after each exposure, the Petitioner returned to his baseline condition - that of mild airway obstruction. (R.Ex.2 at Page 16)

Dr. Hyers acknowledged that in October 2014, when the Petitioner went to St. Elizabeth's Hospital after the second exposure, initial pulmonary testing found that his pulmonary function test (and specifically peak flow rates) were low – measured in the 60's or 70's. After medication, they were measured at over 400. Petitioner's best flow rate was 500. That is 87% of normal. (R.Ex.2 at Page 28).

Dr. Hyers agrees with Dr. Tuteur that exacerbations of Petitioner's asthma can lead to "remodeling" of the airways. (R.Ex.2 at Page 31). Remodeling results from scarring and muscle hypertrophy. (R.Ex.2 at Page 32). The remodeling of the airways narrows the airways. (R.Ex.2 at Page 32). Narrowing in airways limits both expiration and inspiration. (R.Ex.2 at Page 32).

In general, the greater number and greater severity of exacerbations, the greater likelihood of remodeling. (R.Ex.2 at Page 32).

Dr. Hyers believes that the Petitioner's pre-existing asthma was transiently aggravated by the two exposures. (R.Ex.2 at Page 33). The diagnosis of asthma was made, according to Dr. Hyers, by the family doctors at Illini Family Medicine. (R.Ex.2 at Page 34).

As regards the Petitioner's use of medications indicating possible pre-existing asthma, Dr. Hyers acknowledged that Petitioner was given albuterol (possibly for asthma) just three times over four years – – namely from 2003 through 2007 (R.Ex.2 at Page 44) but not at any other time before the first exposures. He had only one prescription for Advair before the exposure. (R.Ex.2 at Page 41).

Dr. Hyers agrees that Petitioner will not return to normal. (R.Ex.2 at Page 53).

Dr. Hyers believes that his condition is probably irreversible. (R.Ex.2 at Page 53).

In sum, Dr. Hyers does not dispute that Petitioner had a pulmonary reaction to the two exposures. Nor does he dispute that the exposure caused the reaction. However, in his view, the Petitioner's reactions temporarily aggravated pre-existing asthma. The exposures left him no worse, because Petitioner returned to "baseline" each time. More, the Petitioner could not be said to have "irritant-induced asthma" because that diagnosis only applies when a person does not already have asthma before the exposure to the irritant.

Summary of Dr. Roth's Deposition

Adele Roth, M.D. testified for the Petitioner.

She graduated Phi Beta Kappa from the University of Illinois and also from the Southern Illinois University School of Medicine.

She has practiced medicine in Belleville, Illinois for more than 30 years.

She is the Petitioner's primary care physician, having treated him since 1999.

Between 1999 and the year of Petitioner's injury, she saw him 2 to 3 times per year. (P.Ex.9 at Page 11). She has been Petitioner's sole family practitioner for that period of time. (P.Ex.9 at Page 11).

One of the first conditions for which Dr. Roth provided treatment to the Petitioner back in 1999 was for cardiopulmonary symptoms that were as-yet undiagnosed. In an effort to find a diagnosis, she referred him to a pulmonologist. That pulmonologist sent Petitioner for a full pulmonary function test, according to her records. It was normal. (P.Ex.9 at Page 14). There was no follow up. (P.Ex.9 at Page 15).

Petitioner was also diagnosed by Dr. Roth with sleep apnea. (P.Ex.9 at Page 16). Dr. Roth referred Petitioner to Dr. Dothager for the condition. Dr. Dothager was a local pulmonologist. (P.Ex.9 at Page 16). He treated Petitioner for sleep apnea but not anything else.

Significantly, Dr. Dothager never treated Petitioner for asthma. (P.Ex.9 at Page 25). He only treated for sleep apnea (P.Ex.9 at Page 25), and nothing that Dr. Dothager ever communicated to Dr. Roth suggested a diagnosis of asthma. (P.Ex.9 at Page 25).

Over the years, Dr. Roth treated Petitioner for various other conditions including: rhinitis, sinusitis, bronchitis, various upper respiratory illnesses and so forth. (P.Ex.9 at Page 17).

At times, Petitioner complained of shortness of breath. Dr. Roth testified that that is a symptom of bronchitis and other conditions, including pneumonia. She occasionally prescribed Albuterol for the condition. (P.Ex.9 at Page 21). She also prescribed Advair in 2005. (Ex.9 at Page 23)

Dr. Roth testified that Petitioner did not have chronic wheezing or even much difficulty breathing over the years of treatment. She did not believe that Petitioner needed continuous bronchodilators or steroids before the initial exposure of September 4, 2013. (P.Ex.9 at Page 27).

She stated that most of the time he had upper respiratory infections that caused or aggravated bronchospasm. (P.Ex.9 at Page 28).

She did not believe he ever had asthma as a debilitating condition. (P.Ex.9 at Page 29).

He was never affected other than when he had infections or bad allergies or other conditions of his health. (P.Ex.9 at Page 29).

Petitioner never missed work because of cough, cold, rhinitis, bronchitis or anything similar before the initial exposure. (P.Ex.9 at Page 29). In her experience, Petitioner was a man who enjoyed working and always wanted to work hard and get back to work. (P.Ex.9 at Page 30).

Dr. Roth had never seen the kind of shortness of breath the Petitioner experienced until after his initial date of exposure. She knows of no other plausible causes of his shortness of breath besides the exposures at work that are the subject of this claim. (P.Ex.9 at Page 30).

According to Dr. Roth, Petitioner's respiratory function never returned to the pre-injury baseline. (P.Ex.9 at Page 31).

Regarding the appearance of the word "asthma" in her records, she stated it was considered as a possible diagnosis that would explain the symptoms he had in 1999. (P.Ex.9 at Page 36).

As it turned out, those symptoms were cardiovascular and largely, or else completely, resolved by the cardiac catherization he underwent.

Dr. Roth never diagnosed Petitioner with COPD. (P.Ex.9 at Page 38).

Petitioner is a non-smoker. (P.Ex.9 at Page 43).

Dr. Roth testified that Petitioner had a tendency to have nasal congestion and allergic rhinitis over the years. He had increased frequency of upper respiratory infections from sinusitis and bronchitis. Dr. Roth does not think Petitioner had severe or moderate asthma. (P.Ex.9 at Page 50).

Dr. Roth testified that she does not consider the Petitioner to have traditional asthma and the only way his symptoms would mimic traditional asthma is if he had a simultaneous upper respiratory infection. Dr. Roth goes on to say that she cannot recall, after reviewing her charts, that his symptoms ever met that threshold prior to the exposures. (P.Ex.9 at Page 50).

When asked to testify whether she believed the condition was aggravated on a permanent basis, Dr. Roth stated Petitioner has more of a "persistent tendency to always have bronchospasm now." (P.Ex.9 at Page 51). She thinks his airway is very much more sensitive than it used to be. (P.Ex.9 at Page 52).

Medical Records in Evidence

The most exhaustive records are those of Dr. Roth and Illini Family Medicine. (P. Ex. 1). Those records contain the word "asthma" prior to Petitioner's exposures - many times. However, the records contain no clinical examination for asthma, nor do they record or report a test result either confirming or suggesting asthma. At various times, Petitioner had one, two or perhaps three of the clinical signs of asthma (as described by Dr. Hyers), but he never had all four of them. "Asthma" was a diagnosis frequently assumed, if not ever carefully diagnosed.

The records address asthma most directly in the note of January 23, 2013. Under history of present illness, the note indicates the patient "was to be evaluated for asthma." It states he "had asthma first diagnosed in adulthood." It states he has attacks on average "once per year." It states he is currently "at baseline," and is "not having an exacerbation." He was not taking medications. He had no symptoms related to asthma.

Note this medical record is obviously a computer-generated form that was completed not by the Petitioner, nor by Dr. Roth, but by Lisa Engel, a medical assistant. Medical assistants, if certified, are generally done so through a community or junior college. They are not medically trained treaters or examiners.

The same medical record, which states the "medical problems to be addressed today include as well (routine follow-up)" contains no clinical information, lab work, test results, complaints, symptoms, treatment, medication or plan with respect to asthma.

The note states Petitioner had a normal respiratory rate and pattern with no distress, bronchi, wheezes, or rubs. He was not given any instructions or treatment with respect to the asthma. He was told only to follow up in six months.

Other pre-printed records from Illini Family Medicine check-space next to "asthma" under a more general heading, "assessment."

Sometimes in the records "asthma" is checked. Sometimes not.

For example, on January 31, 2012, Petitioner saw the doctor for a lump on his neck and watering, painful eyes. Under "A" for assessment, "asthma" is checked. There is a referral to an ophthalmologist and concern over getting a PSA reflected in the note. There is no other mention of "asthma."

Contrariwise, on May 4, 2011, asthma is not marked. He was experiencing wheezing, among other symptoms. He was given an antibiotic. There is no follow up to that visit.

In a note dated February 14, 2011, the assessment contains the space to check asthma and it is unchecked.

On August 9, 2010, the same box for asthma is checked. However, Petitioner was having no problems with breathing or coughing or wheezing or tightness of the chest.

On February 22, 2010, Petitioner had a fever and the sudden onset of a sore throat and cough. He was found to have bronchospasm. Asthma is not checked in that note. Nor is it in the previous note dated June 30, 2009

It was not checked on April 27, 2009.

On February 16, 2009, the Petitioner was wheezing and the note contains the word asthma, but under "assessment", asthma is not checked. He was given a prescription for Albuterol and an antibiotic.

On April 25, 2007, about two years earlier, asthma is not checked.

It is checked on December 5, 2005. On that date, the doctor prescribed an antibiotic. He was having frequent urination and painful kidney stone symptoms. There are no symptoms relating to asthma.

On June 16, 2004, he presented with tightness between his shoulders, shortness of breath and a cough and sore throat. An antibiotic was ordered. Asthma was not checked.

He was diagnosed with bronchitis, but not asthma, with symptoms of bronchospasm on June 18, 2003. On that day he was given an antibiotic plus an Albuterol inhaler.

There is no mention of asthma prior to that date in Dr. Roth's records.

Most pertinent to the claimed injury, Dr. Roth's records also indicate she saw Petitioner on September 5, 2013, five days after the initial exposure and ER treatment. The records note he returned to work immediately. His symptoms on that date included cough, chest tightness, shortness of breath and wheezing. These are the four clinical signs of asthma as set forth by Dr. Hyers. It is the first time all four were present at the same time on exam.

The history of chemical exposure was noted on that date, and he was diagnosed at that time with "acute bronchitis." He continued, as directed, using the albuterol inhaler given to him at the hospital. He was also given a prescription for prednisone to help with his breathing.

Dr. Roth saw him again on September 19, ten days later. He was only somewhat improved, according to the record. He suffered from cough, chest tightness, chest congestion and dyspnea - i.e. trouble breathing. The record also indicates she was referring him to a pulmonologist.

One diagnosis on that date was "contact with and (suspected) exposure to other potentially hazardous chemicals" [*sic*].

Petitioner introduced the records of Respondent's IME, Dr. Puricelli. (P. Ex. 6) She was not directly involved in the workers' compensation cases. She saw Petitioner at the request of Respondent's employee benefits department.

Dr. Puricelli examined the Petitioner on March 30, 2015. She saw him again on April 18, 2017.

Her histories of the exposures are consistent with those found in other records. She used the phrases "reactive airway disease" and also "reactive airway dysfunction" to describe Petitioner's condition. Dr. Puricelli does not contest the claim that the condition was work-related. Nor does she offer a plausible alternative cause other than the exposures. She performed a record review before the first exam. She does not record a pre-exposure history of "asthma".

Following the first exam, and noting his job requirements based upon an essential function survey provided by the Respondent, she concluded he could not return to his normal duties at that time.

She performed another exam and record review in 2017. At that time, she had concluded that he was disabled for all occupations.

The records of St. Elizabeth's Hospital describe the detailed symptomology and acute deficits following both exposures. Of note, the initial ER records state Petitioner had a history of emphysema which he denied and which is not reflected in any other medical record. It also states he previously suffered from West Nile Virus, though there is no evidence of that.

The medical records of Dr. Tuteur contain the environmental testing by ALS performed on the liquid substance to which the Petitioner claimed to be exposed.

The records contain the test results and also certain representations regarding the authenticity of the sample, a clear chain of custody and the fact that the sample was stored in

accordance with analytical method requirements. The testing contractor, ALS, which is located in Simi Valley, California, confirmed the validity and authenticity of the results.

The test results show the presence of various chemicals in their respective concentrations. For example, the concentration of benzene is set forth as 80 µg per kilogram or 80 ppm.

Dr. Tuteur specifically commented on benzene. According to OSHA the short-term exposure limit (STEL) to airborne benzene is 5 ppm for 15 minutes. See https://+www.osha.gov/chemicaldata/chemResult.html?recNo=491.

The testing also indicates that exposure to methyl mercaptan (the "rotten egg" smell added to natural gas") was 557 ppm, significantly above the company's acceptance limits of 50-135.

Petitioner is currently under the care of Dr. Anderson who took over care from Dr. Tuteur at Washington University. Like Dr. Tuteur, he has concluded that is it "unsafe" for Petitioner to return to work. (See, e.g., Dr. Anderson's note of March 31, 2017 embedded in the records of Dr. Roth. "A prescription was provided to Rick and his wife stating that it is unsafe for him to return to work at this time. I recommended that in the future they provide us with paperwork to fill out.")

Petitioner sees Dr. Anderson approximately every six months. It is Dr. Anderson who prescribed oxygen for Petitioner (as of the March 31, 2017 visit). At subsequent visits in November of 2017 and May of 2018 - at which times Petitioner also underwent successful spirometry testing - the records show his condition was not improving. For example, he continues to need oxygen. Dr. Anderson's primary diagnosis (among four) is "chemically-induced bronchial reactivity."

Summary of Annette Duncan's Testimony

Petitioner's wife, Annette Duncan, testified at the hearing. She has been married to Petitioner for forty-three years. (T. 13). On the morning of the first exposure, according to Ms.

Duncan, the Petitioner was not coughing or wheezing. Nor had he been taking albuterol or any other kind of inhaler or steroid. Nothing was out of the ordinary. (T. 14). Up until the date of first exposure, Petitioner never had reactions to things like cleaning products used in the home, cooking in the home, sawdust, pesticides, or any other odors in the environment. He had never sought medical attention for any of those things either. Nor was he restricted at work in that regard. (T.17).

Instead, he did household repairs, chores and small repairs around the house. He worked on his car, took vacations, was active socially, burned leaves, wore clothing that Mrs. Duncan had cleaned for him and went into stores that sold detergent and cleaning supplies. All of that has changed dramatically. (T. 18-20). Each and every one of those potential irritants now causes Petitioner respiratory distress. (T. 27). If Petitioner does try to get out and socialize, he does so at the suggestion of a doctor. (T. 25-26).

Petitioner's house is now full of environmental protections. Mrs. Duncan tries to control his environment. Everything is changed in the house from using soap powders, deodorants, and lotions to using vinegar and water instead of Clorox. Even doing the laundry is different. That is because all of those triggers result in a respiratory reaction. Mrs. Duncan testified that it is difficult for Petitioner to be outside because he frequently experiences triggers. Sometimes, when driving around, Petitioner must turn off the air conditioner in the car to avoid fumes coming in the car. Sometimes they must pull over to administer a breathing treatment with the inhaler. Generally, she drives as a result. (T. 27-30).

Mrs. Duncan testified that her husband has not been the same since the day of his first exposure. (T. 33). His baseline has never gone back to zero. The condition, from her layperson perspective, is that he has just gotten worse since then. (T. 33 and T. 35).

With regard to the second exposure, she had breakfast with him on the morning of that day. As usual, she was trying to control the household environment. He did not have a reaction that morning, nor had he had one the night before. (T. 34). The next thing she heard he was in the emergency room. According to Mrs. Duncan, in the forty-three years they were married, Petitioner had bronchitis three times and once he had pneumonia.

Mrs. Duncan, on cross-examination, did not remember when Petitioner took Flonase (for allergies) but does remember that he was prescribed Advair when he had pneumonia. She remembers he had wheezing during his bout with either bronchitis or pneumonia. According to Mrs. Duncan, Petitioner was given albuterol when he had bronchitis so that he could avoid missing work.

Summary of Cory Duncan's Testimony

Cory Duncan testified on behalf of the Petitioner. He is the son of the Petitioner. He lived with his father until the age of twenty-four. He has continued to see him nearly on a daily basis ever since. At the time of the first exposure, he had the same job as Petitioner, working for the same employer. He also had the same job title and the same job duties, and he worked out of the same Belleville plant. (T. 45-49).

Before the first exposure, he and his dad would hunt and fish together. They would shotgun hunt together. Even after hundreds, if not thousands, of shells, Cory testified he never once saw his father have reaction to the gun powder. (T. 50-51).

He frequently wore cologne around his father but his father never used to have a reaction to it. (T. 51). Since the exposures, Cory has seen his father cough, grab his chest, get red and wheeze when exposed to certain triggers. Id. When they were younger, father and son also took a

keen interest in drag races. They were around burning rubber, cleaners, solvents, fuels and exhaust very frequently --- without any difficulties. (T. 52-52). His father did things like sweat joints, burn leaves and perform maintenance on cars without any kind of reaction. (T. 55).

According to Cory, his father did not return to a "base level" of symptoms after the exposures. (T. 65).

Summary of Petitioner's Testimony

The Petitioner testified that he was sixty-six years of age. He testified that his voice was considerably different at trial that day as a result of triggers in the environment. (T. 69-70).

He described how, on the date of first exposure, he and his men were inspecting a gas line thought to be out-of-service. It was a four-inch cast-iron pipe. When they cut the pipe in order to remove it, an unknown liquid came out, even though it was thought to be a gas line. (T. 71-72).

The Petitioner was cutting the pipe in a ditch. The ditch soon filled up with the liquid. Initially the liquid was clear, but as the ditch filled up, the liquid turned colors and became foamy. (T. 72-73). Ultimately, the Petitioner confirmed that benzene was found in the sample of that liquid from his employer. (T. 73).

After about twenty minutes of exposure to the fumes in the ditch, Petitioner walked to his truck to radio a report to his supervisor. That was when symptoms began. He told his supervisor in the same conversation he had a tight chest and it was hard to breathe and he had a rusty taste in his mouth. (T. 74-75). About a half an hour later, a supervisor showed up and took Petitioner to the emergency room. Petitioner explained he was breathing the gaseous fumes produced by the liquid as it was coming out and filling up the ditch. Symptoms began after about twenty minutes, which was the time of the exposure. Petitioner said Al Hoernis, a co-worker, took the sample from

the site and gave it to the employer, and it was later analyzed. (Petitioner was in the ditch when the liquid came out; Al Hoernis was not.) He later learned benzene was in the sample. (T. 76-77).

Those results, he said, were given to Dr. Tuteur, who talked with him about them. (T. 77).

The Petitioner uses an inhaler and was required to use his inhaler during the course of the hearing. He is scheduled to take it every 4 to 6 hours or as needed if he gets exposed to a trigger. The Petitioner testified he had taken the albuterol five times since he'd been at the Commission's office. (T. 79).

At the hearing, Petitioner was using an oxygen tank. The Petitioner testified that, on the day of the hearing, he was using more oxygen than usual because, since 7:00 a.m, he had been exposed to various triggers, beginning outdoors, but including perfumes, colognes, paint from a building being painted nearby, and so forth. (T 80-81).

The Petitioner testified that neither Dr. Tuteur, Dr. Puricelli, nor Dr. Roth ever authorized him to return to work. (T. 82). Only Dr. Hyers suggested he could return to work. Id.

The Petitioner explained the second exposure. He said there was a very strong odor like gas or a gas leak. There were forklifts running and they run on propane and they were close to him. There were high levels of fumes. He experienced a tight chest, he had shortness of breath, his vocal cords swelled up and he tried to get out outside. Unfortunately, at that time, there were many diesel trucks lined up with their engines on, producing exhaust fumes. The fumes made the situation worse. He came back into the building and he was eventually taken to the emergency room by a supervisor. He went to St. Elizabeth's, where he was admitted. He received treatment which helped his acute symptoms. He followed up with Dr Tuteur. (T. 88-91).

The Petitioner used a demonstrative exhibit to testify to his levels of symptomology at different times. He explained that he had an initial onset of severe symptoms immediately after the

first exposure. Those symptoms partly resolved with treatment, but they did not resolve completely and he did not return to baseline. (T. 112-113).

When he was exposed again, he experienced an immediate and aggressive rise in the severity of the symptoms. (T. 113-114).

As before, after hospitalization and medication, the extent of his symptoms diminished, but he did not return to baseline. (T. 114). His condition has slowly worsened since. Id. Before that October 2014 exposure he had never had a reaction to similar fumes before.

The Petitioner confirmed that he asked Ameren to return to work after the second exposure. In fact, he pleaded with them to return to work. He had multiple discussions with Pam Boone about returning to work but they never offered any work at all.

He went to June Blaine at the request of Ameren. June Blaine is the Respondent's chosen vocational rehabilitation specialist. She interviewed him and gave him an achievement test. He told her that he wanted to return to work. He told her he would be open to more education or training. She never assisted him in trying to find work. Nor did anyone else. She also didn't follow up with him; Petitioner never saw her again. Petitioner nonetheless looked for work.

Some of the Petitioner's effort in searching for a job is found in Petitioner's Exhibit 10. That exhibit has more than 500 job contacts the Petitioner made when looking for a job. None offered Petitioner any work.

The Petitioner confirmed that he went to see J. Stephen Dolan for vocational assessment. The Petitioner confirmed that the limitations in daily activities set forth in Mr. Dolan's report remain accurate today. Mr. Dolan concluded that he was not employable.

The Petitioner testified he is not diabetic, nor does he have emphysema. He has never smoked. He has never missed a day of work because of back pain or any back condition. (T. 116-

117). He had heart surgery a few years ago but missed no work as a result, not a single day. (T. 117).

He does not have high blood pressure. (T. 118). He has high cholesterol for which he takes a pill. It is controlled. Id. He has sleep apnea. For that he uses a breathing apparatus at night. Id. He was using that breathing apparatus before his first exposure. Id.

He does not remember ever missing work for bronchitis. (T. 120). He did miss a small amount of work when he got pneumonia. Id.

He remembered seeing Dr. West, the pulmonologist, in Belleville. Dr. West never advised the Petitioner that he had asthma or any other respiratory condition. The Petitioner did not remember Dr. West sending him for any testing or recommending any follow-up. No testing or follow-up is contained in the medical records. (T. 121).

After he returned to work following the first exposure, he was on restrictions that both he and his job were able to accommodate. It often required his coworkers to help him in special ways. (T. 123-124). As modified, he could do the job. Id.

Petitioner testified that before the date of first exposure, he never had a reaction to smoke, fumes, chemicals, pesticides, or anything that he encountered on the job. (T. 125). He has experienced reactions to those triggers since that time. Id.

The Petitioner denied that he was ever diagnosed with asthma. (T. 131). The Petitioner remembered being prescribed albuterol, Flonase, and Advair. He is not on either Flonase or Advair now. (T. 133-134). He has never been diagnosed with emphysema or COPD. (T. 139).

The Petitioner was asked about certain portions of the surveillance videos that were entered into evidence. In particular, he described being upwind of the barbecue grill and any smoking that may have been happening on the day that he was at the Elks Lodge. (T. 144).

The Petitioner was never prescribed a mask; nonetheless he sometimes wears them. He has two different kinds that he wears. He does so in order to try to control the environment. It depends on the air, and whether not it is hot or cold. He generally does not wear a mask, however, when on oxygen. (T. 153-155). He started oxygen on April 12, 2017. It was prescribed by Dr. Anderson. (T. 155). When he gets exposed to more triggers, he needs to increase the oxygen level. He can regulate the oxygen level. (T. 157).

Standard of Review

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). Whether the claimant established an injury arising out of and in the course of his employment has long been held to be a question of fact for the Commission, which "will not be disturbed unless it is against the manifest weight of the evidence." *City of Springfield v. Illinois Workers' Compensation Comm'n*, 388 Ill.App.3d 297, 312, 901 N.E.2d 1066, 1079 (2009). "As the trier of fact, the Commission is primarily responsible for resolving conflicts in the evidence, assessing the credibility of witness, assigning weight to evidence, and drawing reasonable inferences from the record." *ABF Freight System v. Workers' Compensation Comm'n*, 2015 IL App (1st), 45 N.E.3d 757. On review, the Commission's finding is against the manifest weight of the evidence only when "the opposite conclusion is clearly apparent." *City of Springfield*, 388 Ill.App.3d at 312-13, 901 N.E.2d at 1079. "[T]he appropriate test is whether there is sufficient evidence in the record to support the Commission's determination." *Dig Right In Landscaping v. Workers' Compensation Comm'n*, 16 N.E.3d 739 (1st Dist. 2014).

The Commission's decision contains several factual errors. For example, the decision states that "Dr. Tuteur did not have all the records from Dr. Roth/Illini Family Medicine. Nevertheless, he refuted any diagnosis of asthma prior to [the exposures]." In fact, Dr. Tuteur testified that he not only "had" the records of Dr. Roth, but also that he had reviewed them before his deposition on January 26, 2015. (P.Ex.8, Page 18) Those records of Petitioner's treatment go back to 1999. Dr. Tuteur specifically testified about events in Petitioner's record as far back as 2002. And his testimony addresses, based on Dr. Roth's records, the central issue in the Commission's decision – whether or not Petitioner had pre-existing asthma.

The proper basis for Tuteur's opinions (i.e. whether or not he had the benefit of Dr. Roth's records) matters because the Commission specifically found the testimony of Respondent's IME, Dr. Hyers, "more compelling than that from Dr. Tuteur, given that Dr Hyers had all relevant documentation and testified accordingly as to Petitioner's pre-existing asthma and symptoms in accord therewith."

Again, Dr. Tuteur did have the evidence, as is plain from his testimony. He testified at length about the Petitioner's possible pre-existing asthma, going so far as to judge the credibility of that diagnosis. (See P.Ex.8, Pages 18-26.)

The Commission also found, repeatedly stated, and relied upon the finding, that Petitioner returned to a physiological "baseline" after each exposure. That conclusion is also incorrect.

The Commission did not have a reliable pre-exposure value or metric from which to compare. In other words, no "baseline" exists. That said, objectively, Dr. Tuteur testified that Petitioner's post-exposure bronchodilator value worsened from May to October of 2014 when he tested them. (P.Ex.8, Page 32) Therefore, it is impossible to conclude that Petitioner "returned to

baseline" shortly after the initial exposure (unless the exposure made him breathe better – a fact belied by the emergency room records at the time.)

Separately, Dr. Puricelli's notes accurately comment on the fact that Petitioner's FEC and FEV-1 values on Petitioner's pulmonary function test in October of 2014 were only 82% and 78% of predicted, respectively. (Dr. Roth testified about the only prior testing - a pulmonary test performed in 1999 in a workup that ultimately led to Petitioner's cardiac catheterization. The "full pulmonary function test" was normal. (P.Ex.9 at 14). It showed only minimal obstructive pattern on spirometry that was never followed up on with any kind of treatment. Id.)

Subjectively, not only did Petitioner and Petitioner's family testify he was worse, but Dr. Roth specifically testified that Petitioner "just kept getting more short of breath with time" after the exposure. (P.Ex.9 at Page 51). When asked specifically if Petitioner had returned to baseline, Dr. Roth replied that he had not. (P.Ex.9 at 31).

Less significant, but certainly emblematic, is the Commission's finding that Mr. Hoernis was "in the same spot" as the Petitioner when the Petitioner was exposed (and was himself exposed). That is not a fair reading of the record. Petitioner testified that he was in a ditch and that Hoernis was ***not*** in the ditch at the time the contaminated liquid ran out of the pipe ("He was not in the ditch [when the water came out]." T.141) Nor could Petitioner or anyone state that Hoernis was even exposed. Id.

Very significant is the Commission's finding that "it is not disputed Petitioner has a significant condition of asthma." Quite the contrary, that question is hotly disputed, and the dispute runs throughout the record.

For example, Petitioner was seen at the emergency room after each exposure, and on the second occasion he was admitted overnight. In the first instance, the emergency room diagnosis

was not asthma. It was chemical exposure. In the discharge notes after the exposure, Dr. Wuller's diagnosis is reactive airway disease.

The first treating doctor, Dr. Tuteur, did not diagnose asthma. At deposition, he discussed that potential diagnosis at length, given the fact the word "asthma" appears repeatedly in Petitioner's primary care physician records. He believed, at most, Petitioner had mild quiescent asthma, noting no treatment was ever initiated for that diagnosis, that the diagnosis was made without objective pulmonary testing, and that the patient did not use medications relating to pulmonary function except rarely while experiencing other conditions like bronchitis. Dr. Tuteur never treated Petitioner for asthma, nor did his successor at Washington University/Barnes, Dr. Anderson, who was still treating Petitioner when the case proceeded to hearing.

Dr. Roth testified "I do not remember him having asthma as a debilitating condition, that he was affected, other than when he didn't have infections or bad allergies or you know, other conditions of his health." (P. Ex. 9 at Page 29). She said it never caused him to miss work. Id.

She went on to say, "I don't think that he had what I think [of] as severe asthma or moderate asthma. Could I label that as mild asthma? Possibly, but it's not even what I think of as traditional asthma that you get conditions of bronchospasm. Unless you have an upper respiratory infection with it, I don't think he would ever get that that I remember to the best of my knowledge and after reviewing my charts." (P.Ex. 9 at P 50).

The Petitioner testified he was unaware he had been diagnosed with asthma, if in fact he had.

Dr. Puricelli's records do not use asthma as a diagnosis or potential diagnosis.

Whether or not, and to what extent, Petitioner had asthma was disputed at trial. To find otherwise is to ignore a large portion of the record below.

That, even if the Petitioner did in fact have asthma prior to the two chemical exposures, that does not prevent his injury from being compensable. The case law is well-settled that a work injury is compensable within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel Co. v. Industrial Comm'n,* 6 Ill.2d 296, 128 N.E.2d 718 (1955). Further, a work injury is compensable within the meaning of the Act when it is traceable to a definite time, place and cause and occurs in the course of the employee's employment. *Mathiessen & Hageler Zinc Co. v. Industrial Board,* 284 Ill. 378, 120 N.E. 249 (1918). The fact that the employee had a pre-existing condition, even though the same result may not have occurred had the employee been in normal health, does not preclude a finding that the employment was a causative factor. *County of Cook v. Industrial Comm'n,* 69 Ill.2d 10, 370 N.E.2d 520 (1977).

If the Commission had merely concluded Petitioner had asthma, this Court might disagree. This Court, however, would not set aside the decision on that basis alone. However, the Commission's conclusion goes further. The Commission concluded that Petitioner had asthma, that the asthma was only temporarily twice aggravated by the work-related exposures, and that the asthma also simultaneously and independently progressed from symptomatology that never required treatment or loss of time from work to symptomatology that is so severe that Petitioner requires oxygen and his voice is altered. Such a conclusion cannot be supported on this record.

The Commission's decision leans heavily on the accurate-but-incomplete conclusion that Petitioner quickly returned to work after the first exposure. Although he returned to work after that first exposure, he was medically restricted. He had to avoid irritants that triggered reactions, and he could not perform his work as before. He was acutely sensitive to particulates and fumes,

though he had never been before. His symptoms increased with time, as set forth in Exhibit 12. On May 12, 2014, his treating doctor took him off of work. Respondent began paying TTD.

Reliable medical evidence exists from that time. After the initial exposure, Petitioner saw Dr. Roth. Dr. Roth prescribed medicine. Respondent directed Petitioner to Dr. Tuteur. Dr. Tuteur personally examined Petitioner on November 6, two months after the first date of accident. He examined Petitioner again on February 7, 2014, and again on May 9, 2014, at which time Dr. Tuteur advised Petitioner to remain off of work.

The records of those examinations catalog Petitioner's circumstances after he returned to work. His symptoms only got worse. He was having problems at work and off the job. He frequently reacted to irritants, despite trying to avoid them. Dr. Tuteur, concerned for Petitioner's health and safety, took Petitioner off of work due to his experiences on the job.

Closely related to his prompt return is the Commission's faulty conclusion that Petitioner was "quite active outdoors." Evidence of outdoor activities came from videos and testimony. From the testimony, it is obvious that Petitioner has suffered a dramatic change in lifestyle – on and off the job. That testimony was not disputed, and Respondent did not call anyone to challenge it.

The video evidence was created by Respondent's investigators, who surveilled Petitioner over four years. The videos show a lot of sedentary activity, like sitting and driving. For example, Petitioner drove to a restaurant drive-thru. He drove (or was driven) to medical appointments.

The videos also show Petitioner standing and slow walking. For example, he walks to his mailbox. Sometimes he walks with his oxygen, which is in his backpack.

The videos depict Petitioner sometimes putting on a mask before entering a building or pumping gas.

Frequent spot checks of the residence by the investigators usually yielded nothing. The surveillance proved definitively that Petitioner did not leave his house often, and when he did, it was not for long.

Respondent surveilled Petitioner in 2014, 2015, 2016 and 2017. There is no video of the Petitioner "speed" or "power" walking, jogging, running, hiking, biking, hunting, fishing, boating, shooting, climbing, swimming, skiing, lifting weights, bowling, going to a tavern, going to friends' or families' homes, going to a party, spending more than an insignificant amount of time shopping or eating inside a restaurant, mowing, weed-whacking, trimming, digging, gardening, painting, sealing, constructing, demolishing, cleaning, spraying, picking, cutting, burning, chain-sawing, working on a car or truck, working on a small-engine machine, metalworking, woodworking or washing anything.

The Commission refers to a video that depicts Petitioner attending an outdoor charity event sponsored by the Elks. In it, Petitioner removes two children's bikes from a pickup. The bikes are small.

He also commingles with the crowd, and at one point is near the BBQ and also near a smoker. The video speaks for itself. Petitioner testified he located himself so as to avoid triggering irritants. There was no testimony or evidence otherwise. He was near the BBQ and the smoke for a matter of minutes.

Far from being "quite active" as the Commission described him, the video proves that Petitioner was inactive. He spent his time in a sedentary position or else performing light/very light physical activity. Because there is un-impeachable proof of Petitioner's wide ranging, vigorous activity before the exposure, evidence of the dramatic change in activities and abilities after the

exposure supports Petitioner's claim of medical causation. It proves the first exposure was a watershed – and therefore a causative element. He was never the same after that first exposure.

The Commission incorrectly concluded Petitioner experienced only a temporary aggravation (of underlying asthma). That conclusion is belied by the fact that Petitioner has been under active treatment for a breathing problem ever since the first exposure. He has never not been under a doctor's care since the exposure. In the four years and nine months between exposure and trial, he worked only 8 months. That was the period immediately after the exposure - September through May, plus another three weeks before the second exposure. He did not return to work after the second exposure. He has been returned to work only by the Respondent's IME - no one else. In fact, the Respondent's own disability insurance examining doctor has found him unable to work as a result of this condition. Dr. Puricelli found that, without oxygen assisting his breathing, Petitioner's blood oxygen saturation falls to 91 within five minutes.

Finally, the Commission seemingly took no notice or account of Dr. Puricelli's opinion. She is one of four doctors who saw Petitioner. Dr. Roth (#1), the primary care physician since 1999, and Dr. Tuteur (#2) to whom Petitioner was sent by Corporate Claims, both believed the exposure(s) caused Petitioner's condition. Dr. Hyers (#3), the Section 12 examiner, did not. The Petitioner was also examined twice, however, by Dr. Puricelli (#4). She is Respondent's examiner for purposes of disability insurance. She twice found him unable to work, solely on the basis of his history of reactive airway disease (not asthma) and her own examinations. Her opinion deserved consideration, but was given none.

Conclusion

The Commission's erroneous fact-finding led it to several invalid conclusions. As a result, the decision is against the manifest weight of the evidence. The Commission's decision is therefore reversed. Cause is remanded for further proceedings.

So ordered.

Julie K. Katz
JUDGE

ENTERED: October 8, 2020

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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC027834
Case Name	DUNCAN, RICKY A v. AMEREN ILLINOIS
Consolidated Cases	13WC031742
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	22IWCC0138
Number of Pages of Decision	48
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	David Nelson
Respondent Attorney	William Lemp

DATE FILED: 4/12/2022

/s/Carolyn Doherty, Commissioner

Signature

22IWCC0138

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ricky Duncan,

Petitioner,

vs. NO: 17 WC 27834
19 IWCC 0327

Ameren Illinois,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from an order of the Circuit Court of St. Clair County. In accordance with the order of the circuit court entered on October 8, 2020, the Commission considers the issues of medical expenses, temporary total disability, and permanent total disability, and being advised of the facts and law, concludes that Petitioner is entitled to benefits pursuant to the Illinois Workers' Compensation Act for the reasons stated below.

I. PROCEDURAL BACKGROUND

Petitioner's consolidated claims (Nos. 13 WC 31742 and 17 WC 27834), both involving exposures to Petitioner's lungs, were heard by the arbitrator on June 26, 2018. In a decision filed on August 14, 2018, the arbitrator found that Petitioner proved that he suffered accidents, but failed to prove that his condition of ill-being was causally connected to the exposures at work and that Petitioner suffered only temporary exacerbations of underlying asthma. Petitioner sought a review by the Commission, which issued a Decision and Opinion on Review affirming and adopting the arbitrator's decision on June 26, 2019. Petitioner then sought administrative review in the Circuit Court of St. Clair County. On October 8, 2020, the circuit court entered an order finding a causal connection and remanding the matter "for further proceedings." *Duncan v. Ameren Illinois*, No. 19 MR 199 (Cir. Ct. St. Clair County, Oct. 8, 2020).

II. FINDINGS OF FACT

The Commission hereby incorporates by reference the "Statement of Facts" contained in the arbitration decision filed on August 14, 2018, attached hereto and made a part hereof, to the extent it does not conflict with the order filed in the Circuit Court of St. Clair County on October 8, 2020. The Commission also incorporates by reference the circuit court order, which delineates the relevant facts of the case and the court's analysis of causal connection, attached hereto and made a part hereof. The Commission further adopts and incorporates by reference the additional findings of fact contained in its Decision and Opinion on Remand in No. 13 WC 31742.

III. CONCLUSIONS OF LAW

Having found that Petitioner's current condition ill-being was causally connected to his work-related exposures in both 13 WC 31742 and 17 WC 27834, the circuit court has remanded the consolidated cases to the Commission for further proceedings. Accordingly, the Commission adopts the conclusions of the circuit court regarding accident and causal connection in the consolidated matters. As a result, in this matter 17 WC 27834, the Commission concludes that all benefits resulting from the causally related conditions of ill-being to be awarded Petitioner, including medical expenses, temporary total disability, and permanent partial disability, are awarded by the Commission its Decision and Opinion on Remand in the companion case of No. 13 WC 31742. No award of additional benefits is made herein.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's condition of ill-being at the time of the arbitration hearing was causally connected to his work accidents on September 4, 2013 and October 8, 2014.

IT IS FURTHER FOUND BY THE COMMISSION that medical expenses, temporary total disability, and permanent partial disability at issue in this matter 17 WC 27834 are awarded by the Commission its Decision and Opinion on Remand in the companion case of No. 13 WC 31742. No award of additional benefits is made herein.

No additional bond beyond that required for removal of this cause to the Circuit Court by Respondent in case No. 13 WC 31742 is required. 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 12, 2022

d: 04/07/22
CMD/kcb
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

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

22IWCC0138

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNCAN, RICKY A
Employee/Petitioner

Case# **13WC031742**
17WC027834

AMEREN IL
Employer/Respondent

On 8/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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1241 LEMP &MURPHY PC
DONALD MURPHY
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WEBSTER GROVES, MO 63119

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

☐ 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

Ricky Duncan
Employee/Petitioner

v.

Ameren, IL
Employer/Respondent

Case # 13 WC 031742

Consolidated cases: 17-WC-027834

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **Tuesday, June 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 **09/04/13 and 10/08/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$103,833.60**; the average weekly wage was **$1,996.80**.

On the date of accident, Petitioner was **61/62** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of **$18,954.97** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$18,954.97**.

Respondent is entitled to a credit of **$84,415.61** under Section 8(j) of the Act.

ORDER

THE ARBITRATOR DENIES PPD BENEFITS AND ANY ADDITIONAL TTD OR MEDICAL BENEFITS. SEE ATTACHED.

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

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

Signature of Arbitrator

8/11/18
Date

AUG 14 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

☐ 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

Ricky Duncan
Employee/Petitioner

v.

Ameren, IL
Employer/Respondent

Case # 13 WC 031742

Consolidated cases: 17-WC-027834

STATEMENT OF FACTS

I. Testimony at Trial

The initial witness was Annette Duncan, wife of Petitioner, Ricky Duncan. At the time of trial, they had been married 43 years. She testified that prior to the initial exposure on 09/04/13 he had no trouble breathing, no coughing, wheezing, or the like. Further, that he was not taking any types of medication, such as Albuterol inhaler or steroids. (Tr. 13-15).

Annette Duncan did testify that there were three occasions of breathing symptoms prior to the exposure on 09/04/13, which she described as episodes of bronchitis and pneumonia. (Tr. 15).

Annette Duncan testified that prior to 09/04/13 her husband had no issues with doing work around the house, taking vacations, burning leaves, exposure to detergents or cleaning items around the house. (Tr. 18-20).

Annette Duncan testified that between the initial exposure on 09/04/13 and the subsequent exposure on 10/08/14 her husband did not want to leave the house, was concerned he would have attacks and was depressed. (Tr. 23-24).

There was discussion as to surveillance which was undertaken following the initial exposure (on 08/30/14), which Annette Duncan had reviewed. This involved a charity event at an Elks Lodge, to which both she and her husband belong. She admitted this showed her husband near a BBQ grill, allegedly though away from the smoke. (Tr. 21-23).

Allegedly after the exposures, Annette Duncan started changing filters in the house, removing soap powders, deodorants, lotions, or similar items, to avoid her husband having any triggers. (Tr. 26-29).

Allegedly after the two exposures, Petitioner's symptoms never returned to baseline, getting worse. (Tr. 33-34).

On cross-examination, Annette Duncan testified she was aware that her husband was seeing Dr. Roth at Illini Family Medicine prior to both exposures. Further, that prior to both exposures, he had been prescribed Flonase, Addair (an inhaler), the latter allegedly given with pneumonia, statements as to wheezing, statements as to possibility of asthma, prescriptions of Biaxin and Albuterol. (Tr. 36-38).

Annette Duncan was not aware that on 01/28/13, prior to the initial or either exposure, Dr. Roth had diagnosed her husband with asthma. Further, that there was reference by Dr. Roth to her husband having a frequency of asthma attacks about once a year. Finally, that on 08/24/13, two weeks prior to the initial exposure, her husband was reporting fatigue and difficulty sleeping. (Tr. 38-41).

The second witness at trial was Corey Duncan, Petitioner's son. Both have been employed over the years at Ameren as gas journeymen. He was not present at the initial exposure on 09/04/13. However, he did testify as to growing up with his father, going hunting, shooting guns, wearing cologne with no issues, his father not having any reactions to orders, perfumes or the like. (Tr. 49-51). However, that after the second exposure, he would cough excessively, wheeze and the like. (Tr. 51-52).

Prior to the exposures, Corey Duncan testified that his father and he would go to drag races, where they would be exposure to fluids and fumes. However, that after the exposures, they have not been able to do so. (Tr. 53-55).

Corey Duncan testified that when his father visits (after the exposure) he has to make sure there are no cleaners, "smelly stuff", perfumes or the like, for fear of reaction. (Tr. 62-63). Further, that he had no such problems prior to the exposure. (Tr. 63-64).

On cross-examination, Corey Duncan confirmed he was not aware of any emergency room visits involving his father in terms of pulmonary problems other than on the exposure of 09/04/13 and 10/08/14. Further that after the exposures, his father would wear a mask when it was cold but that in terms of smells, but that the mask "didn't really block a whole lot out". (Tr. 65-66).

The third witness was Petitioner, Ricky Duncan. At trial, he was 66 years old. He testified his voice was different, because of having walked into the building where the trial took place. (Tr. 69-70).

There was a discussion as to the initial exposure on 09/04/13, when Petitioner and another employee were cutting a four inch cast iron line. Water came out, then some type of liquid. It emptied into a nearby ditch, and it was noticed the water was turning red and foamy. (Tr. 70-72).

Allegedly after this exposure, Petitioner had a tight chest, with difficulty breathing. He called his supervisor, who took him to the emergency room. (Tr. 74).

At the time of trial, Petitioner testified he was using an inhaler every four to six hours as needed, or if he would be involved with triggers. He was also carrying oxygen. On the date of trial, he had already used one bottle of oxygen, greater than usual. (Tr. 79-80).

Petitioner talked about various triggers, including paint, perfumes and the like. (Tr. 81).

Petitioner only missed a couple of days off work after the initial exposure. He did not begin missing time from work until 05/12/14, approximately seven months thereafter. He was paid TTD from 05/12/14 through 09/21/14. He then returned to work on 09/22/14. (Tr. 83-84).

Following the return to work on 09/22/14, there was the subsequent exposure on 10/08/14. Petitioner was in the crew room, when he smelled a very strong order of gas. He stated there was limited ventilation, and he again experienced chest pain and difficulty breathing (Tr. 88-90). He was taken by ambulance to the hospital. He was admitted overnight and then discharged the second day. (Tr. 92-93).

After the subsequent exposure, Petitioner returned to Dr. Tuteur, who authorized lost time. (Tr. 101-102). Since then, Dr. Tuteur never released Petitioner back to work. (Tr. 104).

Petitioner testified as to a job search log with approximately 500 contacts, further his evaluation with a vocational specialist, June Blaine (at the request of Respondent) and with Stephen Dolan (at the request of his attorney). There has been no vocational rehabilitation effort. (Tr. 107-108).

On cross-examination, there was a discretion with Petitioner as to his extensive prior treatment with Dr. Roth. That began in October of 1998 with a history of trouble breathing and chest pain. Then in July of 1999, shortness of breath and a referral to Dr. West for pulmonary function testing. Petitioner did not remember Dr. West suggesting obstructive airways disease as far back as August of 1999. Nor did he remember Dr. West talking about the possibility of a work up for asthma. Petitioner testified to knowledge, he was never diagnosed with asthma. (Tr. 129-131).

There was discussion as to excessive fatigue in May of 2001, shortness of breath and coughing in December of 2001, bronchospasm and being prescribed an Albuterol inhaler in June of 2003, prescribed Flonase in October of 2004, Advair in November of 2005, wheezing and a prescription of Biaxin and Albuterol in February of 2009, chest tightness and wheezing in May of 2001. (Tr. 131-135).

Petitioner was confronted with a history from Dr. Roth on 01/23/13, approximately 7 ½ months prior to the initial exposure of 09/04/13, referencing asthma. Petitioner again stated he was not diagnosed with asthma. Further, that he did not understand the discussion as to frequency of attacks as being approximately once a year, as reflected in the records from Dr. Roth. (Tr. 136-137).

Petitioner indicated that the co-employee who was with him at the time of the initial exposure on 09/04/13 was Al Hoernis. Mr. Horenis and Petitioner were in the same spot when the material came out. They both cut their pipe. Petitioner did not know whether Mr. Horenis had any symptoms with this exposure or had any treatment. (Tr. 140-141).

Petitioner admitted returning to work a couple of days after the initial exposure on 09/04/13 until being taken off again in May of 2014, approximately eight months. During that time frame, he was a gas journeyman lead man, and would work in the field. He did try to control his environment during that time frame. (Tr. 142-143).

There was a discussion as to the surveillance and BBQ at the Elks Lodge on 08/30/14. Petitioner had reviewed the video. He admitted to being in the vicinity of the BBQ and fumes, also an individual smoking a cigarette. However, allegedly that he was upwind. (Tr. 143-144).

Petitioner admitted that after the initial exposure on 09/04/13 and the return to work a couple of days after, he did not wear a mask during that time frame, up until the subsequent exposure on 10/08/14. (Tr. 154). Further, that thereafter, he would wear the mask only if it was cold or if there was dust flying. As of the date of trial, he was no longer wearing the mask, being on oxygen. (Tr. 155).

Petitioner was never prescribed the mask, rather he just went to the store to buy a mask. He admitted that the masks identified on surveillance did not hold back fumes. (Tr. 156).

Petitioner testified that other than an emergency room for a bee sting, there have been no emergency room visits since 10/08/14. Specifically, no emergency room visits thereafter based on breathing or lung issues. (Tr. 157-158).

As of the trial date, Petitioner still had group insurance through Ameren, with that policy honoring treatment relating to pulmonary issues. (Tr. 160).

As to the job search log, Petitioner admitted that the vast majority, 90% to 95% indicated the employers were not hiring or no jobs were open. (Tr. 150).

II. Medical Records and Deposition Testimony of Dr. Roth

Dr. Roth is Petitioner's family physician, and has been since the late 1990's. She discussed Petitioner's pulmonary symptoms over the years, including after the two exposures. It was her opinion that "I do not think he has returned to baseline after those exposures." (Tr. 31).

On cross-examination, there was a discussion as to Petitioner's history of pulmonary or arguably asthma, dating back to 1999. She admitted that as far back on 07/28/99 she referred Petitioner to Dr. West, with a history of shortness of breath on exertion. (Tr. 34). Further, that his oxygen level that date was 68, whereas she would usually "like to see them between 80 and 100". Thus, that the oxygen level as of that date was below normal. (Tr. 35). Dr. Roth admitted that on 08/08/99 there was a discussion as to potential obstructive airways disease. Further, that

in August of 1999 there was a statement as to the possibility of a diagnosis of asthma. (Tr. 35-36).

Dr. Roth prescribed Albuterol on 06/18/03, designed to open up the airways and relax the spasm in the airways. She admitted an Albuterol inhaler is sometimes prescribed for asthma. (Tr. 41).

On 11/23/05 Dr. Roth prescribed Advair 250/50. (Tr. 41-42).

On 02/16/09 there was reference to Petitioner having reported wheezing, with a questionable history of asthma. (Tr. 42-43).

Dr. Roth admitted that as far back as February of 2009 there was concern as to a potential diagnosis of asthma. Further, that wheezing would be consistent with a diagnosis of asthma. Finally, noting that as of 01/23/13 there was a specific discussion as to "asthma first diagnosed in adulthood . . . to be conceived as attacks once per year". (Tr. 43-44).

There was a visit on 08/15/13, less than a month prior to the initial claimed exposure. Therein, reference to the Petitioner having fatigue for the last five years or so. (Tr. 44-45).

III. Medical Records and Deposition Testimony of Dr. Tuteur

Dr. Tuteur initially saw Petitioner on 11/06/13. He noted the Petitioner had never smoked cigarettes. Further, with a history of pneumonia and chest discomfort over the years. He also made reference to the prior evaluation with Dr. West "which is the only date I have", with reference to the possibility of asthma dating back to 2002. (Tr. 8-10).

Dr. Tuteur had a history of the Petitioner cutting a pipe, with exposure to materials thereafter. He talked about the return to work in May of 2014, recommending environmental control. He then discussed the subsequent exposure on 10/08/14. (Tr. 12-16).

Dr. Tuteur talked about every exposure being an exacerbation, involving remodeling of the airways. Further, that this would be irreversible. (Tr. 17).

In discussing references to the possibility of pre-existing asthma or asthma in general, Dr. Tuteur advised "I view use of the term asthma – and I will give you an anecdote that will explain this – as very much of the concept of the blind man – the multiple blind men assessing the camel". He then went into his view as to why only specialists such as he had would be qualified to make or discuss the diagnoses. (Tr. 24-26).

Dr. Tuteur testified that the exposures on 09/04/13 and 10/08/14 made Petitioner worse, that he would not get better, that condition would be permanent and irreversible. (Tr. 28-30).

As of the date of his deposition on 01/26/15, Dr. Tuteur admitted that he last seen the Petitioner in October of 2014. (Tr. 35). He admitted that there is no way he could testify as to what Petitioner had been doing since October of 2014, since he had not seen him since then.

Dr. Tuteur did admit on cross-examination that "not everybody gets remodeling every time you have an exacerbation". Further, that pulmonary function can remain the same. Further, that that would be no way to objectively indicate whether there had in fact been remodeling. (Tr. 36-37).

Dr. Tuteur indicated that he knew Dr. Hyers in a professional capacity. Further, that he had no reason to question his integrity or qualifications as a pulmonary specialist. (Tr. 38).

As to the degree of disability, Dr. Tuteur admitted that he did not recommend Petitioner be home bound and not capable of going to any type of work environment. Further, "I strongly feel that for total global health, for persons with this condition, that some form of remunerative activity, as long as it is safe from a pulmonary stand point should be attempted". He then discussed the possibility of a work place home environment, environmental control, ventilation, etc. (Tr. 40-41).

In discussing potential irritants, such as perfume, Dr. Tuteur admitted that there was no evidence in the record as to Petitioner needing to seek additional treatment when he was allegedly exposure to any such triggers. (Tr. 46).

IV. IME Reports and Deposition Testimony of Dr. Hyers

Dr. Hyers is a board certified pulmonary specialist, who took an initial evaluation of Petitioner on 09/09/13. His diagnosis was asthma. He indicated that if the exposure on 09/04/13 in any way impacted the asthma, it was transient. He noted that the acute problems seem to have resolved by the time of a follow up with Dr. Roth at Illini Family Medicine within a couple of weeks thereafter. He did not feel Petitioner had sustained any permanent impairment as a result of the industrial exposure on 09/04/13.

An initial deposition of Dr. Hyers took place on 11/24/14. Therein, he reiterated his findings and conclusions that Petitioner had an acute exposure on 09/04/13, but had returned to baseline within several weeks thereafter, as documented in a follow up visit to Dr. Roth at Illini Family Medicine.

On cross-examination, Dr. Hyers noted Petitioner had a history of wheezing for 10 to 12 years prior to the exposure on 09/04/13. (Tr. 25-26). He disagreed with Dr. Tuteur as to the diagnosis of irritant induced asthma. He stated this diagnoses would be based on somebody who developed asthma without a prior history, noting Petitioner had a prior history of asthma. (Tr. 27).

Dr. Hyers went into background in terms of diagnosed asthma. He stated it is consistent with shortness of breath, chest tightness, coughing and wheezing here with a stethoscope. (Tr. 29). He also noted spirometry testing, though he was not aware Petitioner had any such testing prior to the initial exposure on 09/04/13. (Tr. 29).

Dr. Hyers noted the 01/21/13 report from Dr. Roth (prior to the initial exposure) with reference to medical problems to be addressed that date, including asthma. (Tr. 34).

Dr. Hyers also noted reference to a diagnosis of asthma as far back as to 02/16/09, including recurrent wheezing and cough. (Tr. 35).

In discussing references in Dr. Roth's records and diagnosis of bronchitis, Dr. Hyers noted that it is often a substitute from a general practitioner or non-specialist for asthma. (Tr. 43-44). Dr. Hyers admitted Petitioner would be susceptible to flare-ups of asthma, and medical treatment relating thereto. (Tr. 56).

Dr. Hyers testified that a prescription for Addair is typically for asthma or COPD – with no indication Petitioner had COPD. Further, that this was prescribed as far back as 11/23/05. (Tr. 64).

Dr. Hyers' initial deposition on 11/24/14 was soon after the subsequent exposure on 10/08/14, and he did not have sufficient information to reply to the impact of that event.

Thus, there was a second evaluation with Dr. Hyers on 12/08/14. That incorporated a history of the subsequent event on 10/08/14 and treatment with Dr. Tuteur thereafter. Dr. Hyers reiterated his previous opinion that Petitioner did not suffer from irritant induced asthma or irritant induced bronchoreactivity; rather, noting a history of asthma dating back over 10 years. He did not feel any exposure at Ameren would increase the risk of asthma attack more than any exposure away from the work place. He advised Petitioner had no permanent partial disability as the result of the exposures on 09/04/13 and/or 10/08/14. Further, that he did agree with Dr. Tuteur that Petitioner should take common sense precautions to avoid and mitigate exposure to fumes, smokes, molds, sense and other irritants, "this is advice that is appropriate for all asthmatics".

Dr. Hyers' supplemental deposition took place on 03/18/15.

Dr. Hyers testified that the subsequent visit on 12/08/14 there was an attempt at another spirometry. However, that Petitioner did not give a reproducible effort. He thought that was based on lack of effort. (Tr. 11). He noted everything else was normal with regard to the evaluation on 12/08/14, specifically, that Petitioner was in no distress, lung exam was normal, he moved about the office normally. (Tr. 11).

Dr. Hyers noted the Petitioner had pre-existing asthma, dating ten years prior to any claimed exposure at Ameren. He did not feel that any exposure at Ameren would be any more risky than his moving about in the general environment. He did not believe that Petitioner sustained any permanent partial disability as the result of either the exposure on 09/04/13 or 10/08/14. (Tr. 12-13).

Dr. Hyers noted that after the initial exposure of 09/04/13 and a visit at Dr. Roth/Illini Family Medicine a week or two later the findings had returned to baseline. Similarly, after the subsequent exposure on 10/08/14 and a return to Dr. Tuteur, within a couple of weeks, the findings had returned to baseline. (Tr. 16).

V. Surveillance

Surveillance on 08/30/14 revealed Petitioner to be in the area of a BBQ, also an individual smoking, with no apparent distress. He was able to move some bicycles out of the back of a pickup truck.

Subsequent surveillance over many years revealed Petitioner sometimes wearing a mask around at a gas station, sometimes not wearing a mask.

VI. Martin Upchurch/SEA Limited.

Mr. Upchurch is an engineer. He reviewed surveillance, identifying the different types of masks Petitioner was earning over the years. It is was his opinion that neither would have been protective of gas fumes or related odors.

VII. Vocational Assessment of June Blaine

June Blaine testified regardless of the causation, he was restricted in his job opportunities. She indicated that he would be employable, but at a reduced earnings, in the range of $10.00 to $12.00 per hour.

VIII. Stephen Dolan

Mr. Dolan examined the Petitioner at the request of his attorney. It was Mr. Dolan's opinion that Petitioner would be permanency and totally disabled as the result of his pulmonary condition.

FINDINGS OF FACT

It is found Petitioner has symptoms comparable with the diagnosis of asthma dating back to the late 1990's. Further, that there was several specific references to a potential diagnoses of asthma, along with inhaler prescribed on different dates prior to the exposures on 09/04/13 and 10/05/14.

At a follow up with Dr. Roth on 09/09/13 there was a reference to the exposure on 09/04/13, with acute symptoms.

At a follow up with Dr. Roth on 09/19/13 there was an essentially negative evaluation. On that date, diagnoses were cough and acute sinusitis. Petitioner was advised to avoid cigarette smoke.

At a time when Petitioner was claiming reactivity to different exposures and problems with exposures at work, surveillance revealed that he was capable of being outdoors, in the vicinity of a BBQ, in the vicinity of an individual smoking cigarettes, able to engage in exertional activity, all without apparent distress.

There was a subsequent exposure on 10/08/14. There was no objective testimony from Dr. Tuteur or otherwise as to Petitioner's clinical findings or symptoms having materially changed thereafter.

Dr. Tuteur did not have all records from Dr. Roth/Illini Family Medicine. Nevertheless he refuted any diagnosis of asthma prior to the 09/04/13 and 10/08/14, suggesting only a pulmonary specialist such as he would be capable of making that diagnoses.

Dr. Hyers evaluated Petitioner on two occasions, one after the initial exposure, and one after the subsequent exposure. He did review the records from Dr. Roth/Illini Family Medicine. He documented references to diagnosis of asthma and medications (Advair and Albuterol) prior to either exposure that would be consistent with a diagnosis of asthma.

Dr. Hyers testified credibly that shortly after both exposures, Petitioner's symptoms abated, at least with regard to objective findings.

Dr. Hyers did not dispute that Petitioner, having asthma, would be susceptible to further aggravations, as would be the case will all asthmatics. However, he did not feel that either exposure of 09/04/13 and 10/08/14 resulted in any permanent impact on Petitioner's underlying asthma.

It is found that Dr. Hyers' testimony is more compelling than that from Dr. Tuteur, given that Dr. Hyers had all relevant documentation and testified accordingly as to Petitioner's pre-existing asthma and symptoms in accord therewith; further with Dr. Hyers noting after both exposures, a relevantly prompt return to similar objective findings.

CONCLUSIONS OF LAW

It is found Petitioner sustained temporary aggravations of his pre-existing asthma via the exposures on 09/04/13 and 10/08/14.

It is noted at trial that Petitioner testified as to significant and permanent exacerbations after the initial exposure of 09/04/13 and the subsequent exposure of 10/08/14. However, his credibility is undermined by the fact that after what was alleged to the most significant event on 09/04/13, he returned to work within a couple of days thereafter. Further, at a time when he was claiming significant and unabated symptoms, he was found on surveillance to be quite active outdoors, exposed to multiple fumes, without any evident of impairment or difficulty relating thereto.

It is not disputed Petitioner has a significant condition of asthma. In fact, that is documented by references to asthma and symptoms compatible to asthma for more than 10 years prior to either claimed exposure.

Petitioner has the burden of proof on all issues, including medical causation.

It is found that Petitioner has only sustained his burden of proof in determining that there was a temporary aggregation of underlying asthma as the result of the exposures on 09/04/13 and 10/08/14; failing to meet his burden of proof as to any indication of permanent aggravation or permanent partial disability relating thereto in terms of the underlying asthma – rather, that any perceived progression of symptoms would be compatible with his ten plus year history of symptoms compatible with asthma.

All other issues are rendered moot.

IN THE CIRCUIT COURT
TWENTIETH JUDICIAL CIRCUIT
ST. CLAIR COUNTY, ILLINOIS

RICKY A. DUNCAN,)
)
Plaintiff/Petitioner,)
) Case No.: 19-MR-199
v.)
)
ILLINOIS WORKERS' COMPENSATION)
COMMISSION and AMEREN ILLINOIS,)
)
Defendants/Respondents.)

ORDER

This cause coming before the Court; the Court, being fully advised in the premises and having jurisdiction over the subject matter, finds the following:

This case involves two claims that were consolidated for trial. Each claim involves an exposure to Petitioner's lungs. The two dates of injury are September 4, 2013 and October 8, 2014.

Trial took place before an arbitrator in Collinsville on June 26, 2018. Petitioner, Petitioner's wife and Petitioner's son all came to the hearing and testified live. At the hearing, the parties submitted deposition testimony of three doctors – Petitioner's treating doctors, Tuteur and Roth, and also Respondent's IME, Dr. Hyers.

The Arbitrator concluded that Petitioner failed to prove one element of the case, causal connection, and thus found for the Respondent. Petitioner reviewed (appealed) and the Commission confirmed (affirmed) by adopting the Arbitrator's opinion (and without writing its own opinion).

In the present case, the Commission determined that Petitioner did not establish causal connection by a preponderance of the evidence. For the reasons that follow, the Court finds the

Commission's decision was against the manifest weight of the evidence because the opposite conclusion is clearly apparent to the Court.

Summary of Dr. Tuteur's Deposition

Peter G. Tuteur, M.D. testified on behalf of the Petitioner.

Dr. Tuteur is a pulmonologist. He is an Associate Professor of Medicine at Washington University School of Medicine. According to his CV, he attended Johns Hopkins and then the University of Illinois School of Medicine. He is a member of various professional societies, has consulting relationships and board memberships that are widespread, and has published numerous articles over the years on subjects relating to pulmonology and industrial asthma.

He has a general interest in occupational environmental lung disease.

He first saw the Petitioner on November 6, 2013 at the request of Corporate Claims Management. (P.Ex.8, Page 8).

At that time, Petitioner gave a history that he was installing a gas service, and he cut a four-inch galvanized pipe out of which clear liquid and fumes emanated. In the process, he developed significant pulmonary symptoms of breathlessness, coughing, wheezing, and chest tightness that resulted in an emergency room visit and subsequent hospitalization. (P.Ex.8, Page 10-11).

Prior to September 2013 he did not have a tendency to react in a significant way to the pervasive irritants in our daily lives. (P.Ex.8, Page 12).

There was no plausible etiology other than the September exposure in the workplace to account for the symptoms Petitioner experienced. (P.Ex.8, Page 13).

He had the methacholine challenge test and that was positive. Overall, the clinical examination revealed he had bronchial reactivity. (P.Ex.8, Page 14).

Dr. Tuteur saw Petitioner a second time in November 2013, again at the request of Corporate Claims Management for the specified purpose of assessment of disability. (P.Ex.8, Page 14).

Later Dr. Tuteur saw Petitioner at the request of Dr. Adele Roth. He instituted a plan of Advair. It was suggested that the Petitioner eliminate environmental triggers at work to avoid the bronchial reactivity -- particularly natural gas, diesel exhaust, and other particulate matter and fumes. (P.Ex.8, Page 15).

Dr. Tuteur saw Petitioner again in May 2014. At that time, Petitioner described instances of recurrent exacerbations. The doctor advised him to try more intensive management of his environment. (P.Ex.8, Page 15).

When he was seen again in October 2014, he had recently experienced a short hospitalization in response to an additional exposure in the workplace. The doctor tried to convince him he should not work at that place of employment. (P.Ex.8, Page 16).

Regarding causation, Dr. Tuteur stated that Petitioner suffered an injury when he was exposed to chemicals on the job on September 4, 2013. (P.Ex.8, Page 27).

The injury was an injury to his airways. (P.Ex.8, Page 27).

Most acutely, the injury was inflammation. The subsequent development of serious bronchial reactivity followed as a result. (P.Ex.8, Page 27).

The condition is permanent. (P.Ex.8, Page 28).

In offering that opinion, Dr. Tuteur had the benefit of Respondent's independent testing of the substance to which the Petitioner was exposed. The analyses showed a variety of solvents, including benzene and mercury, to which the Petitioner was exposed. (P.Ex.8, Page 30). These

low-molecular-weight inorganic chemicals are known to initiate the condition from which the Petitioner suffers, according to Dr. Tuteur. (P.Ex.8, Page 30).

The condition is irreversible. (P.Ex.8, Page 30). Dr. Tuteur therefore recommended against work. (P.Ex.8, Page 31).

It is medically contra-indicated, he said, for Petitioner to be exposed to conditions and substances that would trigger exacerbations. (P.Ex.8, Page 31).

Dr. Tuteur described Petitioner's problems as a tendency for the pulmonary "architecture" to remodel with each and every exacerbation. Remodeling is the irreversible component of the disease process. It is scarification due to inflammation. (P.Ex.8, Page 36).

The doctor does not believe that Petitioner should stay in his home twenty-four hours a day, seven days a week for the rest of his life. (P.Ex.8, Page 40). He is able to do any work where he is not at risk of being exposed to triggers that exacerbate his condition. (P.Ex.8, Page 40).

Dr. Tuteur encouraged him to be active, to the extent that he can, because it feeds his sense of worth. (P.Ex.8, Page 41).

From a medical standpoint, however, it is important that Petitioner not be exposed to environmental triggers (P.Ex.8, Page 44), and it is very challenging to control adequately the environment. (P.Ex.8, Page 45).

Dr. Tuteur clarified that Petitioner is not allergic to anything. (P.Ex.8, Page 45). His condition is not an allergic process. (P.Ex.8, Page 45). He has an irritant-induced condition. (P.Ex.8, Page 45).

Summary of Dr. Hyers' Deposition

Respondent engaged Thomas M. Hyers, M.D. as its Section 12 examiner.

Dr. Hyers saw the Petitioner on two occasions. Dr. Hyers wrote three reports. He testified on November 24, 2014 and also on March 18, 2015.

Dr. Hyers is a board-certified pulmonologist. He occasionally testifies in the medical-legal context for plaintiffs and for defendants. His private practice is in St. Louis County, Missouri.

Petitioner gave Dr. Hyers substantially the same history as he gave other medical professionals. (R.Ex.1 at Page 10, Lines 13-25).

Dr. Hyers did not accept the diagnosis by Dr. Tuteur of "irritant-induced bronchial reactivity." Dr. Hyers prefers to use the term irritant-induced asthma for similar conditions – although not Petitioner's. (R.Ex.1 at Page 12).

According to Hyers, the x-rays of Petitioner's lungs did not point to severe asthma or COPD. (R.Ex.1 at Page 15). Dr. Hyers does not believe Petitioner suffers from COPD. (R.Ex.1 at Page 13).

Dr. Hyers attempted to conduct testing known as spirometry, which could confirm the existence of asthma, but he could not validate the test results. (R.Ex.1 at Page 15).

Dr. Hyers attributed the inconclusive test results to a lack of reproducible effort by Petitioner. (R.Ex.1 at Page 18).

According to Dr. Hyers, "His respiratory rate was within the normal range, and he didn't appear to be having any respiratory symptoms. He wasn't coughing. He wasn't showing any evidence of other respiratory problems" during the exam. (R.Ex.1 at Page 19).

Dr. Hyers' diagnosis is asthma. (R.Ex.1 at Page 20).

When asked his opinion as to whether the exposure of September 4, 2013 impacted Petitioner's underlying asthma, Dr. Hyers opined "If it did, it was transient." (R.Ex.1 at Page 21).

Dr. Hyers is confident that Petitioner had an underlying asthmatic condition before the exposure of September 4, 2013. (R.Ex.1 at Page 21).

Dr. Hyers believed that Petitioner suffered no permanent impairment as a result of the exposure. (R.Ex.1 at Page 24).

Dr. Hyers stated that "irritant-induced asthma" – which the Petitioner does not have – is a condition that develops with an exposure ***in the absence of a prior history of asthma***." (R.Ex.1 at Page 27).

He doesn't know what the phrase "irritant-induced bronchial reactivity" means. (R.Ex.1 at Page 28).

Dr. Hyers believes that Petitioner had asthma well prior to the exposure in 2013. Dr. Hyers acknowledged that asthma may be diagnosed on the bases of spirometry. (R.Ex.1 at Page 30).

He does not have knowledge of a prior spirometry test for the Petitioner. (R.Ex.1 at Page 32).

Dr. Hyers stated the clinical signs or symptoms of asthma are "shortness of breath, chest tightness, coughing, and wheezing." (R.Ex.1 at Page 32).

He says typically "when you have all four, that's asthma until proven otherwise." (R.Ex.1 at Page 32).

He went on to say "you don't always have four" symptoms. (R.Ex.1 at Page 36).

According to Dr. Hyers, the Petitioner can get better. In other words, the symptoms can improve. (R.Ex.1 at Page 40).

According to Dr. Hyers, there were numerous instances where the word asthma appears in the records of Dr. Adele Roth, the Petitioner's long-time family doctor, and that is his basis for his opinion that Petitioner had asthma prior to the first exposure. (R.Ex.1 at Page 45).

Dr. Hyers acknowledged that the pulmonologist whom Petitioner had seen on numerous previous occasions for sleep apnea, Dr. Dothager, never diagnosed Petitioner with asthma. (R.Ex.1 at Page 46).

Dr. Hyers conceded that the Petitioner was not on any medications at the time of the exposure in 2014. (R.Ex.1 at Page 53).

Prior to the date of exposure, Petitioner had most recently been seen by Dr. Roth at her office on August 15, 2013. At that time, he was asymptomatic with respect to any pulmonary conditions, including asthma, if he had it. (R.Ex.1 at Page 54).

Dr. Hyers agrees that the St. Elizabeth's hospitalization and treatment was reasonable, necessary and related to the exposure. (R.Ex.1 at Page 56, Lines 1-5). He also believes that Dr. Tuteur's treatment was reasonable and necessary for asthma. (R.Ex.1 at Page 56).

Dr. Hyers stated that Petitioner is susceptible to exacerbations. That would include emergency room visits and even overnight hospitalizations. (R.Ex.1 at Pages 56-57).

The exacerbations could be triggered by workplace exposures. (R.Ex.1 at Page 57).

Dr. Hyers was unaware of, and there is no evidence in the record that the Petitioner had any acute exacerbations (of the presumed asthma) leading to treatment before the September 4, 2013 exposure. (R.Ex.1 at Page 60).

Nonetheless, Dr. Hyers does not believe that the specific exposure in September 2013 made Petitioner more susceptible to subsequent exposures or triggers. (R.Ex.1 at Page 67).

Dr. Hyers' second deposition took place on March 18, 2015, after he saw the Petitioner again on December 8, 2014. He took an interval history that included the Petitioner's second exposure on October 8, 2014. (R.Ex.2 at Page 7).

On the date of Hyers' second exam, Dr. Hyers again attempted to obtain a spirometry test and again found its results were unreliable because, in his opinion, the Petitioner did not give a reproducible effort. (R.Ex.2 at Page 10).

Dr. Hyers was the only medical professional who performed that test without being able to elicit reliable test results. The test was successfully performed at St. Elizabeth's Hospital in Belleville on multiple occasions, by Dr. Tuteur at Washington University on multiple occasions and by Dr. Tuteur's successor, Dr. Anderson, at Washington University on multiple occasions.

Dr. Hyers concluded after the second examination that Petitioner had underlying asthma that pre-existed the first workplace exposure on September 4, 2013. (R.Ex.2 at Page 12). Dr. Hyers stated he did not think Petitioner had irritant-induced asthma in the sense that an exposure on or around September 4, 2013 caused ***the onset*** of Petitioner's asthma. (R.Ex.2 at Page 12).

Dr. Hyers did not believe Petitioner incurred any permanent disability as a result of either of the Petitioner's exposures. (R.Ex.2 at Page 13).

According to Dr. Hyers, because irritant-induced asthma is a diagnosis that, by definition, exists only when the Petitioner or individual had no pre-existing asthma, Petitioner could not have that condition (by definition). (R.Ex.2 at Page 14).

In his deposition testimony, Dr. Hyers stated that there were six or seven notations of pre-existing asthma in Dr. Roth's records (i.e. Illini Family Medicine). (R.Ex.2 at Page 15).

Dr. Hyers does not know what originally caused Petitioner's asthma, but he does not believe Petitioner has irritant-induced asthma in the sense that Dr. Tuteur uses that phrase. (R.Ex.2 at Page 12).

Dr. Hyers reiterated that the only real basis for his opinion that Petitioner had pre-existing asthma is the six or seven notations in the Illini Family Medicine records. (R.Ex.2 at Page 15).

Dr. Hyers stated that after each exposure, the Petitioner returned to his baseline condition - that of mild airway obstruction. (R.Ex.2 at Page 16)

Dr. Hyers acknowledged that in October 2014, when the Petitioner went to St. Elizabeth's Hospital after the second exposure, initial pulmonary testing found that his pulmonary function test (and specifically peak flow rates) were low – measured in the 60's or 70's. After medication, they were measured at over 400. Petitioner's best flow rate was 500. That is 87% of normal. (R.Ex.2 at Page 28).

Dr. Hyers agrees with Dr. Tuteur that exacerbations of Petitioner's asthma can lead to "remodeling" of the airways. (R.Ex.2 at Page 31). Remodeling results from scarring and muscle hypertrophy. (R.Ex.2 at Page 32). The remodeling of the airways narrows the airways. (R.Ex.2 at Page 32). Narrowing in airways limits both expiration and inspiration. (R.Ex.2 at Page 32).

In general, the greater number and greater severity of exacerbations, the greater likelihood of remodeling. (R.Ex.2 at Page 32).

Dr. Hyers believes that the Petitioner's pre-existing asthma was transiently aggravated by the two exposures. (R.Ex.2 at Page 33). The diagnosis of asthma was made, according to Dr. Hyers, by the family doctors at Illini Family Medicine. (R.Ex.2 at Page 34).

As regards the Petitioner's use of medications indicating possible pre-existing asthma, Dr. Hyers acknowledged that Petitioner was given albuterol (possibly for asthma) just three times over four years – – namely from 2003 through 2007 (R.Ex.2 at Page 44) but not at any other time before the first exposures. He had only one prescription for Advair before the exposure. (R.Ex.2 at Page 41).

Dr. Hyers agrees that Petitioner will not return to normal. (R.Ex.2 at Page 53).

Dr. Hyers believes that his condition is probably irreversible. (R.Ex.2 at Page 53).

In sum, Dr. Hyers does not dispute that Petitioner had a pulmonary reaction to the two exposures. Nor does he dispute that the exposure caused the reaction. However, in his view, the Petitioner's reactions temporarily aggravated pre-existing asthma. The exposures left him no worse, because Petitioner returned to "baseline" each time. More, the Petitioner could not be said to have "irritant-induced asthma" because that diagnosis only applies when a person does not already have asthma before the exposure to the irritant.

Summary of Dr. Roth's Deposition

Adele Roth, M.D. testified for the Petitioner.

She graduated Phi Beta Kappa from the University of Illinois and also from the Southern Illinois University School of Medicine.

She has practiced medicine in Belleville, Illinois for more than 30 years.

She is the Petitioner's primary care physician, having treated him since 1999.

Between 1999 and the year of Petitioner's injury, she saw him 2 to 3 times per year. (P.Ex.9 at Page 11). She has been Petitioner's sole family practitioner for that period of time. (P.Ex.9 at Page 11).

One of the first conditions for which Dr. Roth provided treatment to the Petitioner back in 1999 was for cardiopulmonary symptoms that were as-yet undiagnosed. In an effort to find a diagnosis, she referred him to a pulmonologist. That pulmonologist sent Petitioner for a full pulmonary function test, according to her records. It was normal. (P.Ex.9 at Page 14). There was no follow up. (P.Ex.9 at Page 15).

Petitioner was also diagnosed by Dr. Roth with sleep apnea. (P.Ex.9 at Page 16). Dr. Roth referred Petitioner to Dr. Dothager for the condition. Dr. Dothager was a local pulmonologist. (P.Ex.9 at Page 16). He treated Petitioner for sleep apnea but not anything else.

Significantly, Dr. Dothager never treated Petitioner for asthma. (P.Ex.9 at Page 25). He only treated for sleep apnea (P.Ex.9 at Page 25), and nothing that Dr. Dothager ever communicated to Dr. Roth suggested a diagnosis of asthma. (P.Ex.9 at Page 25).

Over the years, Dr. Roth treated Petitioner for various other conditions including: rhinitis, sinusitis, bronchitis, various upper respiratory illnesses and so forth. (P.Ex.9 at Page 17).

At times, Petitioner complained of shortness of breath. Dr. Roth testified that that is a symptom of bronchitis and other conditions, including pneumonia. She occasionally prescribed Albuterol for the condition. (P.Ex.9 at Page 21). She also prescribed Advair in 2005. (Ex.9 at Page 23)

Dr. Roth testified that Petitioner did not have chronic wheezing or even much difficulty breathing over the years of treatment. She did not believe that Petitioner needed continuous bronchodilators or steroids before the initial exposure of September 4, 2013. (P.Ex.9 at Page 27).

She stated that most of the time he had upper respiratory infections that caused or aggravated bronchospasm. (P.Ex.9 at Page 28).

She did not believe he ever had asthma as a debilitating condition. (P.Ex.9 at Page 29).

He was never affected other than when he had infections or bad allergies or other conditions of his health. (P.Ex.9 at Page 29).

Petitioner never missed work because of cough, cold, rhinitis, bronchitis or anything similar before the initial exposure. (P.Ex.9 at Page 29). In her experience, Petitioner was a man who enjoyed working and always wanted to work hard and get back to work. (P.Ex.9 at Page 30).

Dr. Roth had never seen the kind of shortness of breath the Petitioner experienced until after his initial date of exposure. She knows of no other plausible causes of his shortness of breath besides the exposures at work that are the subject of this claim. (P.Ex.9 at Page 30).

According to Dr. Roth, Petitioner's respiratory function never returned to the pre-injury baseline. (P.Ex.9 at Page 31).

Regarding the appearance of the word "asthma" in her records, she stated it was considered as a possible diagnosis that would explain the symptoms he had in 1999. (P.Ex.9 at Page 36).

As it turned out, those symptoms were cardiovascular and largely, or else completely, resolved by the cardiac catherization he underwent.

Dr. Roth never diagnosed Petitioner with COPD. (P.Ex.9 at Page 38).

Petitioner is a non-smoker. (P.Ex.9 at Page 43).

Dr. Roth testified that Petitioner had a tendency to have nasal congestion and allergic rhinitis over the years. He had increased frequency of upper respiratory infections from sinusitis and bronchitis. Dr. Roth does not think Petitioner had severe or moderate asthma. (P.Ex.9 at Page 50).

Dr. Roth testified that she does not consider the Petitioner to have traditional asthma and the only way his symptoms would mimic traditional asthma is if he had a simultaneous upper respiratory infection. Dr. Roth goes on to say that she cannot recall, after reviewing her charts, that his symptoms ever met that threshold prior to the exposures. (P.Ex.9 at Page 50).

When asked to testify whether she believed the condition was aggravated on a permanent basis, Dr. Roth stated Petitioner has more of a "persistent tendency to always have bronchospasm now." (P.Ex.9 at Page 51). She thinks his airway is very much more sensitive than it used to be. (P.Ex.9 at Page 52).

Medical Records in Evidence

The most exhaustive records are those of Dr. Roth and Illini Family Medicine. (P. Ex. 1). Those records contain the word "asthma" prior to Petitioner's exposures - many times. However, the records contain no clinical examination for asthma, nor do they record or report a test result either confirming or suggesting asthma. At various times, Petitioner had one, two or perhaps three of the clinical signs of asthma (as described by Dr. Hyers), but he never had all four of them. "Asthma" was a diagnosis frequently assumed, if not ever carefully diagnosed.

The records address asthma most directly in the note of January 23, 2013. Under history of present illness, the note indicates the patient "was to be evaluated for asthma." It states he "had asthma first diagnosed in adulthood." It states he has attacks on average "once per year." It states he is currently "at baseline," and is "not having an exacerbation." He was not taking medications. He had no symptoms related to asthma.

Note this medical record is obviously a computer-generated form that was completed not by the Petitioner, nor by Dr. Roth, but by Lisa Engel, a medical assistant. Medical assistants, if certified, are generally done so through a community or junior college. They are not medically trained treaters or examiners.

The same medical record, which states the "medical problems to be addressed today include as well (routine follow-up)" contains no clinical information, lab work, test results, complaints, symptoms, treatment, medication or plan with respect to asthma.

The note states Petitioner had a normal respiratory rate and pattern with no distress, bronchi, wheezes, or rubs. He was not given any instructions or treatment with respect to the asthma. He was told only to follow up in six months.

Other pre-printed records from Illini Family Medicine check-space next to "asthma" under a more general heading, "assessment."

Sometimes in the records "asthma" is checked. Sometimes not.

For example, on January 31, 2012, Petitioner saw the doctor for a lump on his neck and watering, painful eyes. Under "A" for assessment, "asthma" is checked. There is a referral to an ophthalmologist and concern over getting a PSA reflected in the note. There is no other mention of "asthma."

Contrariwise, on May 4, 2011, asthma is not marked. He was experiencing wheezing, among other symptoms. He was given an antibiotic. There is no follow up to that visit.

In a note dated February 14, 2011, the assessment contains the space to check asthma and it is unchecked.

On August 9, 2010, the same box for asthma is checked. However, Petitioner was having no problems with breathing or coughing or wheezing or tightness of the chest.

On February 22, 2010, Petitioner had a fever and the sudden onset of a sore throat and cough. He was found to have bronchospasm. Asthma is not checked in that note. Nor is it in the previous note dated June 30, 2009

It was not checked on April 27, 2009.

On February 16, 2009, the Petitioner was wheezing and the note contains the word asthma, but under "assessment", asthma is not checked. He was given a prescription for Albuterol and an antibiotic.

On April 25, 2007, about two years earlier, asthma is not checked.

It is checked on December 5, 2005. On that date, the doctor prescribed an antibiotic. He was having frequent urination and painful kidney stone symptoms. There are no symptoms relating to asthma.

On June 16, 2004, he presented with tightness between his shoulders, shortness of breath and a cough and sore throat. An antibiotic was ordered. Asthma was not checked.

He was diagnosed with bronchitis, but not asthma, with symptoms of bronchospasm on June 18, 2003. On that day he was given an antibiotic plus an Albuterol inhaler.

There is no mention of asthma prior to that date in Dr. Roth's records.

Most pertinent to the claimed injury, Dr. Roth's records also indicate she saw Petitioner on September 5, 2013, five days after the initial exposure and ER treatment. The records note he returned to work immediately. His symptoms on that date included cough, chest tightness, shortness of breath and wheezing. These are the four clinical signs of asthma as set forth by Dr. Hyers. It is the first time all four were present at the same time on exam.

The history of chemical exposure was noted on that date, and he was diagnosed at that time with "acute bronchitis." He continued, as directed, using the albuterol inhaler given to him at the hospital. He was also given a prescription for prednisone to help with his breathing.

Dr. Roth saw him again on September 19, ten days later. He was only somewhat improved, according to the record. He suffered from cough, chest tightness, chest congestion and dyspnea - i.e. trouble breathing. The record also indicates she was referring him to a pulmonologist.

One diagnosis on that date was "contact with and (suspected) exposure to other potentially hazardous chemicals" [*sic*].

Petitioner introduced the records of Respondent's IME, Dr. Puricelli. (P. Ex. 6) She was not directly involved in the workers' compensation cases. She saw Petitioner at the request of Respondent's employee benefits department.

Dr. Puricelli examined the Petitioner on March 30, 2015. She saw him again on April 18, 2017.

Her histories of the exposures are consistent with those found in other records. She used the phrases "reactive airway disease" and also "reactive airway dysfunction" to describe Petitioner's condition. Dr. Puricelli does not contest the claim that the condition was work-related. Nor does she offer a plausible alternative cause other than the exposures. She performed a record review before the first exam. She does not record a pre-exposure history of "asthma".

Following the first exam, and noting his job requirements based upon an essential function survey provided by the Respondent, she concluded he could not return to his normal duties at that time.

She performed another exam and record review in 2017. At that time, she had concluded that he was disabled for all occupations.

The records of St. Elizabeth's Hospital describe the detailed symptomology and acute deficits following both exposures. Of note, the initial ER records state Petitioner had a history of emphysema which he denied and which is not reflected in any other medical record. It also states he previously suffered from West Nile Virus, though there is no evidence of that.

The medical records of Dr. Tuteur contain the environmental testing by ALS performed on the liquid substance to which the Petitioner claimed to be exposed.

The records contain the test results and also certain representations regarding the authenticity of the sample, a clear chain of custody and the fact that the sample was stored in

accordance with analytical method requirements. The testing contractor, ALS, which is located in Simi Valley, California, confirmed the validity and authenticity of the results.

The test results show the presence of various chemicals in their respective concentrations. For example, the concentration of benzene is set forth as 80 µg per kilogram or 80 ppm.

Dr. Tuteur specifically commented on benzene. According to OSHA the short-term exposure limit (STEL) to airborne benzene is 5 ppm for 15 minutes. See https://+www.osha.gov/chemicaldata/chemResult.html?recNo=491.

The testing also indicates that exposure to methyl mercaptan (the "rotten egg" smell added to natural gas") was 557 ppm, significantly above the company's acceptance limits of 50-135.

Petitioner is currently under the care of Dr. Anderson who took over care from Dr. Tuteur at Washington University. Like Dr. Tuteur, he has concluded that is it "unsafe" for Petitioner to return to work. (See, e.g., Dr. Anderson's note of March 31, 2017 embedded in the records of Dr. Roth. "A prescription was provided to Rick and his wife stating that it is unsafe for him to return to work at this time. I recommended that in the future they provide us with paperwork to fill out.")

Petitioner sees Dr. Anderson approximately every six months. It is Dr. Anderson who prescribed oxygen for Petitioner (as of the March 31, 2017 visit). At subsequent visits in November of 2017 and May of 2018 - at which times Petitioner also underwent successful spirometry testing - the records show his condition was not improving. For example, he continues to need oxygen. Dr. Anderson's primary diagnosis (among four) is "chemically-induced bronchial reactivity."

Summary of Annette Duncan's Testimony

Petitioner's wife, Annette Duncan, testified at the hearing. She has been married to Petitioner for forty-three years. (T. 13). On the morning of the first exposure, according to Ms.

Duncan, the Petitioner was not coughing or wheezing. Nor had he been taking albuterol or any other kind of inhaler or steroid. Nothing was out of the ordinary. (T. 14). Up until the date of first exposure, Petitioner never had reactions to things like cleaning products used in the home, cooking in the home, sawdust, pesticides, or any other odors in the environment. He had never sought medical attention for any of those things either. Nor was he restricted at work in that regard. (T.17).

Instead, he did household repairs, chores and small repairs around the house. He worked on his car, took vacations, was active socially, burned leaves, wore clothing that Mrs. Duncan had cleaned for him and went into stores that sold detergent and cleaning supplies. All of that has changed dramatically. (T. 18-20). Each and every one of those potential irritants now causes Petitioner respiratory distress. (T. 27). If Petitioner does try to get out and socialize, he does so at the suggestion of a doctor. (T. 25-26).

Petitioner's house is now full of environmental protections. Mrs. Duncan tries to control his environment. Everything is changed in the house from using soap powders, deodorants, and lotions to using vinegar and water instead of Clorox. Even doing the laundry is different. That is because all of those triggers result in a respiratory reaction. Mrs. Duncan testified that it is difficult for Petitioner to be outside because he frequently experiences triggers. Sometimes, when driving around, Petitioner must turn off the air conditioner in the car to avoid fumes coming in the car. Sometimes they must pull over to administer a breathing treatment with the inhaler. Generally, she drives as a result. (T. 27-30).

Mrs. Duncan testified that her husband has not been the same since the day of his first exposure. (T. 33). His baseline has never gone back to zero. The condition, from her layperson perspective, is that he has just gotten worse since then. (T. 33 and T. 35).

With regard to the second exposure, she had breakfast with him on the morning of that day. As usual, she was trying to control the household environment. He did not have a reaction that morning, nor had he had one the night before. (T. 34). The next thing she heard he was in the emergency room. According to Mrs. Duncan, in the forty-three years they were married, Petitioner had bronchitis three times and once he had pneumonia.

Mrs. Duncan, on cross-examination, did not remember when Petitioner took Flonase (for allergies) but does remember that he was prescribed Advair when he had pneumonia. She remembers he had wheezing during his bout with either bronchitis or pneumonia. According to Mrs. Duncan, Petitioner was given albuterol when he had bronchitis so that he could avoid missing work.

Summary of Cory Duncan's Testimony

Cory Duncan testified on behalf of the Petitioner. He is the son of the Petitioner. He lived with his father until the age of twenty-four. He has continued to see him nearly on a daily basis ever since. At the time of the first exposure, he had the same job as Petitioner, working for the same employer. He also had the same job title and the same job duties, and he worked out of the same Belleville plant. (T. 45-49).

Before the first exposure, he and his dad would hunt and fish together. They would shotgun hunt together. Even after hundreds, if not thousands, of shells, Cory testified he never once saw his father have reaction to the gun powder. (T. 50-51).

He frequently wore cologne around his father but his father never used to have a reaction to it. (T. 51). Since the exposures, Cory has seen his father cough, grab his chest, get red and wheeze when exposed to certain triggers. Id. When they were younger, father and son also took a

keen interest in drag races. They were around burning rubber, cleaners, solvents, fuels and exhaust very frequently --- without any difficulties. (T. 52-52). His father did things like sweat joints, burn leaves and perform maintenance on cars without any kind of reaction. (T. 55).

According to Cory, his father did not return to a "base level" of symptoms after the exposures. (T. 65).

Summary of Petitioner's Testimony

The Petitioner testified that he was sixty-six years of age. He testified that his voice was considerably different at trial that day as a result of triggers in the environment. (T. 69-70).

He described how, on the date of first exposure, he and his men were inspecting a gas line thought to be out-of-service. It was a four-inch cast-iron pipe. When they cut the pipe in order to remove it, an unknown liquid came out, even though it was thought to be a gas line. (T. 71-72).

The Petitioner was cutting the pipe in a ditch. The ditch soon filled up with the liquid. Initially the liquid was clear, but as the ditch filled up, the liquid turned colors and became foamy. (T. 72-73). Ultimately, the Petitioner confirmed that benzene was found in the sample of that liquid from his employer. (T. 73).

After about twenty minutes of exposure to the fumes in the ditch, Petitioner walked to his truck to radio a report to his supervisor. That was when symptoms began. He told his supervisor in the same conversation he had a tight chest and it was hard to breathe and he had a rusty taste in his mouth. (T. 74-75). About a half an hour later, a supervisor showed up and took Petitioner to the emergency room. Petitioner explained he was breathing the gaseous fumes produced by the liquid as it was coming out and filling up the ditch. Symptoms began after about twenty minutes, which was the time of the exposure. Petitioner said Al Hoernis, a co-worker, took the sample from

the site and gave it to the employer, and it was later analyzed. (Petitioner was in the ditch when the liquid came out; Al Hoernis was not.) He later learned benzene was in the sample. (T. 76-77).

Those results, he said, were given to Dr. Tuteur, who talked with him about them. (T. 77).

The Petitioner uses an inhaler and was required to use his inhaler during the course of the hearing. He is scheduled to take it every 4 to 6 hours or as needed if he gets exposed to a trigger. The Petitioner testified he had taken the albuterol five times since he'd been at the Commission's office. (T. 79).

At the hearing, Petitioner was using an oxygen tank. The Petitioner testified that, on the day of the hearing, he was using more oxygen than usual because, since 7:00 a.m, he had been exposed to various triggers, beginning outdoors, but including perfumes, colognes, paint from a building being painted nearby, and so forth. (T 80-81).

The Petitioner testified that neither Dr. Tuteur, Dr. Puricelli, nor Dr. Roth ever authorized him to return to work. (T. 82). Only Dr. Hyers suggested he could return to work. Id.

The Petitioner explained the second exposure. He said there was a very strong odor like gas or a gas leak. There were forklifts running and they run on propane and they were close to him. There were high levels of fumes. He experienced a tight chest, he had shortness of breath, his vocal cords swelled up and he tried to get out outside. Unfortunately, at that time, there were many diesel trucks lined up with their engines on, producing exhaust fumes. The fumes made the situation worse. He came back into the building and he was eventually taken to the emergency room by a supervisor. He went to St. Elizabeth's, where he was admitted. He received treatment which helped his acute symptoms. He followed up with Dr Tuteur. (T. 88-91).

The Petitioner used a demonstrative exhibit to testify to his levels of symptomology at different times. He explained that he had an initial onset of severe symptoms immediately after the

first exposure. Those symptoms partly resolved with treatment, but they did not resolve completely and he did not return to baseline. (T. 112-113).

When he was exposed again, he experienced an immediate and aggressive rise in the severity of the symptoms. (T. 113-114).

As before, after hospitalization and medication, the extent of his symptoms diminished, but he did not return to baseline. (T. 114). His condition has slowly worsened since. Id. Before that October 2014 exposure he had never had a reaction to similar fumes before.

The Petitioner confirmed that he asked Ameren to return to work after the second exposure. In fact, he pleaded with them to return to work. He had multiple discussions with Pam Boone about returning to work but they never offered any work at all.

He went to June Blaine at the request of Ameren. June Blaine is the Respondent's chosen vocational rehabilitation specialist. She interviewed him and gave him an achievement test. He told her that he wanted to return to work. He told her he would be open to more education or training. She never assisted him in trying to find work. Nor did anyone else. She also didn't follow up with him; Petitioner never saw her again. Petitioner nonetheless looked for work.

Some of the Petitioner's effort in searching for a job is found in Petitioner's Exhibit 10. That exhibit has more than 500 job contacts the Petitioner made when looking for a job. None offered Petitioner any work.

The Petitioner confirmed that he went to see J. Stephen Dolan for vocational assessment. The Petitioner confirmed that the limitations in daily activities set forth in Mr. Dolan's report remain accurate today. Mr. Dolan concluded that he was not employable.

The Petitioner testified he is not diabetic, nor does he have emphysema. He has never smoked. He has never missed a day of work because of back pain or any back condition. (T. 116-

117). He had heart surgery a few years ago but missed no work as a result, not a single day. (T. 117).

He does not have high blood pressure. (T. 118). He has high cholesterol for which he takes a pill. It is controlled. Id. He has sleep apnea. For that he uses a breathing apparatus at night. Id. He was using that breathing apparatus before his first exposure. Id.

He does not remember ever missing work for bronchitis. (T. 120). He did miss a small amount of work when he got pneumonia. Id.

He remembered seeing Dr. West, the pulmonologist, in Belleville. Dr. West never advised the Petitioner that he had asthma or any other respiratory condition. The Petitioner did not remember Dr. West sending him for any testing or recommending any follow-up. No testing or follow-up is contained in the medical records. (T. 121).

After he returned to work following the first exposure, he was on restrictions that both he and his job were able to accommodate. It often required his coworkers to help him in special ways. (T. 123-124). As modified, he could do the job. Id.

Petitioner testified that before the date of first exposure, he never had a reaction to smoke, fumes, chemicals, pesticides, or anything that he encountered on the job. (T. 125). He has experienced reactions to those triggers since that time. Id.

The Petitioner denied that he was ever diagnosed with asthma. (T. 131). The Petitioner remembered being prescribed albuterol, Flonase, and Advair. He is not on either Flonase or Advair now. (T. 133-134). He has never been diagnosed with emphysema or COPD. (T. 139).

The Petitioner was asked about certain portions of the surveillance videos that were entered into evidence. In particular, he described being upwind of the barbecue grill and any smoking that may have been happening on the day that he was at the Elks Lodge. (T. 144).

The Petitioner was never prescribed a mask; nonetheless he sometimes wears them. He has two different kinds that he wears. He does so in order to try to control the environment. It depends on the air, and whether not it is hot or cold. He generally does not wear a mask, however, when on oxygen. (T. 153-155). He started oxygen on April 12, 2017. It was prescribed by Dr. Anderson. (T. 155). When he gets exposed to more triggers, he needs to increase the oxygen level. He can regulate the oxygen level. (T. 157).

Standard of Review

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). Whether the claimant established an injury arising out of and in the course of his employment has long been held to be a question of fact for the Commission, which "will not be disturbed unless it is against the manifest weight of the evidence." *City of Springfield v. Illinois Workers' Compensation Comm'n*, 388 Ill.App.3d 297, 312, 901 N.E.2d 1066, 1079 (2009). "As the trier of fact, the Commission is primarily responsible for resolving conflicts in the evidence, assessing the credibility of witness, assigning weight to evidence, and drawing reasonable inferences from the record." *ABF Freight System v. Workers' Compensation Comm'n*, 2015 IL App (1st), 45 N.E.3d 757. On review, the Commission's finding is against the manifest weight of the evidence only when "the opposite conclusion is clearly apparent." *City of Springfield*, 388 Ill.App.3d at 312-13, 901 N.E.2d at 1079. "[T]he appropriate test is whether there is sufficient evidence in the record to support the Commission's determination." *Dig Right In Landscaping v. Workers' Compensation Comm'n*, 16 N.E.3d 739 (1st Dist. 2014).

The Commission's decision contains several factual errors. For example, the decision states that "Dr. Tuteur did not have all the records from Dr. Roth/Illini Family Medicine. Nevertheless, he refuted any diagnosis of asthma prior to [the exposures]." In fact, Dr. Tuteur testified that he not only "had" the records of Dr. Roth, but also that he had reviewed them before his deposition on January 26, 2015. (P.Ex.8, Page 18) Those records of Petitioner's treatment go back to 1999. Dr. Tuteur specifically testified about events in Petitioner's record as far back as 2002. And his testimony addresses, based on Dr. Roth's records, the central issue in the Commission's decision – whether or not Petitioner had pre-existing asthma.

The proper basis for Tuteur's opinions (i.e. whether or not he had the benefit of Dr. Roth's records) matters because the Commission specifically found the testimony of Respondent's IME, Dr. Hyers, "more compelling than that from Dr. Tuteur, given that Dr Hyers had all relevant documentation and testified accordingly as to Petitioner's pre-existing asthma and symptoms in accord therewith."

Again, Dr. Tuteur did have the evidence, as is plain from his testimony. He testified at length about the Petitioner's possible pre-existing asthma, going so far as to judge the credibility of that diagnosis. (See P.Ex.8, Pages 18-26.)

The Commission also found, repeatedly stated, and relied upon the finding, that Petitioner returned to a physiological "baseline" after each exposure. That conclusion is also incorrect.

The Commission did not have a reliable pre-exposure value or metric from which to compare. In other words, no "baseline" exists. That said, objectively, Dr. Tuteur testified that Petitioner's post-exposure bronchodilator value worsened from May to October of 2014 when he tested them. (P.Ex.8, Page 32) Therefore, it is impossible to conclude that Petitioner "returned to

baseline" shortly after the initial exposure (unless the exposure made him breathe better – a fact belied by the emergency room records at the time.)

Separately, Dr. Puricelli's notes accurately comment on the fact that Petitioner's FEC and FEV-1 values on Petitioner's pulmonary function test in October of 2014 were only 82% and 78% of predicted, respectively. (Dr. Roth testified about the only prior testing - a pulmonary test performed in 1999 in a workup that ultimately led to Petitioner's cardiac catheterization. The "full pulmonary function test" was normal. (P.Ex.9 at 14). It showed only minimal obstructive pattern on spirometry that was never followed up on with any kind of treatment. Id.)

Subjectively, not only did Petitioner and Petitioner's family testify he was worse, but Dr. Roth specifically testified that Petitioner "just kept getting more short of breath with time" after the exposure. (P.Ex.9 at Page 51). When asked specifically if Petitioner had returned to baseline, Dr. Roth replied that he had not. (P.Ex.9 at 31).

Less significant, but certainly emblematic, is the Commission's finding that Mr. Hoernis was "in the same spot" as the Petitioner when the Petitioner was exposed (and was himself exposed). That is not a fair reading of the record. Petitioner testified that he was in a ditch and that Hoernis was ***not*** in the ditch at the time the contaminated liquid ran out of the pipe ("He was not in the ditch [when the water came out]." T.141) Nor could Petitioner or anyone state that Hoernis was even exposed. Id.

Very significant is the Commission's finding that "it is not disputed Petitioner has a significant condition of asthma." Quite the contrary, that question is hotly disputed, and the dispute runs throughout the record.

For example, Petitioner was seen at the emergency room after each exposure, and on the second occasion he was admitted overnight. In the first instance, the emergency room diagnosis

was not asthma. It was chemical exposure. In the discharge notes after the exposure, Dr. Wuller's diagnosis is reactive airway disease.

The first treating doctor, Dr. Tuteur, did not diagnose asthma. At deposition, he discussed that potential diagnosis at length, given the fact the word "asthma" appears repeatedly in Petitioner's primary care physician records. He believed, at most, Petitioner had mild quiescent asthma, noting no treatment was ever initiated for that diagnosis, that the diagnosis was made without objective pulmonary testing, and that the patient did not use medications relating to pulmonary function except rarely while experiencing other conditions like bronchitis. Dr. Tuteur never treated Petitioner for asthma, nor did his successor at Washington University/Barnes, Dr. Anderson, who was still treating Petitioner when the case proceeded to hearing.

Dr. Roth testified "I do not remember him having asthma as a debilitating condition, that he was affected, other than when he didn't have infections or bad allergies or you know, other conditions of his health." (P. Ex. 9 at Page 29). She said it never caused him to miss work. Id.

She went on to say, "I don't think that he had what I think [of] as severe asthma or moderate asthma. Could I label that as mild asthma? Possibly, but it's not even what I think of as traditional asthma that you get conditions of bronchospasm. Unless you have an upper respiratory infection with it, I don't think he would ever get that that I remember to the best of my knowledge and after reviewing my charts." (P.Ex. 9 at P 50).

The Petitioner testified he was unaware he had been diagnosed with asthma, if in fact he had.

Dr. Puricelli's records do not use asthma as a diagnosis or potential diagnosis.

Whether or not, and to what extent, Petitioner had asthma was disputed at trial. To find otherwise is to ignore a large portion of the record below.

That, even if the Petitioner did in fact have asthma prior to the two chemical exposures, that does not prevent his injury from being compensable. The case law is well-settled that a work injury is compensable within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel Co. v. Industrial Comm'n,* 6 Ill.2d 296, 128 N.E.2d 718 (1955). Further, a work injury is compensable within the meaning of the Act when it is traceable to a definite time, place and cause and occurs in the course of the employee's employment. *Mathiessen & Hageler Zinc Co. v. Industrial Board,* 284 Ill. 378, 120 N.E. 249 (1918). The fact that the employee had a pre-existing condition, even though the same result may not have occurred had the employee been in normal health, does not preclude a finding that the employment was a causative factor. *County of Cook v. Industrial Comm'n,* 69 Ill.2d 10, 370 N.E.2d 520 (1977).

If the Commission had merely concluded Petitioner had asthma, this Court might disagree. This Court, however, would not set aside the decision on that basis alone. However, the Commission's conclusion goes further. The Commission concluded that Petitioner had asthma, that the asthma was only temporarily twice aggravated by the work-related exposures, and that the asthma also simultaneously and independently progressed from symptomatology that never required treatment or loss of time from work to symptomatology that is so severe that Petitioner requires oxygen and his voice is altered. Such a conclusion cannot be supported on this record.

The Commission's decision leans heavily on the accurate-but-incomplete conclusion that Petitioner quickly returned to work after the first exposure. Although he returned to work after that first exposure, he was medically restricted. He had to avoid irritants that triggered reactions, and he could not perform his work as before. He was acutely sensitive to particulates and fumes,

though he had never been before. His symptoms increased with time, as set forth in Exhibit 12. On May 12, 2014, his treating doctor took him off of work. Respondent began paying TTD.

Reliable medical evidence exists from that time. After the initial exposure, Petitioner saw Dr. Roth. Dr. Roth prescribed medicine. Respondent directed Petitioner to Dr. Tuteur. Dr. Tuteur personally examined Petitioner on November 6, two months after the first date of accident. He examined Petitioner again on February 7, 2014, and again on May 9, 2014, at which time Dr. Tuteur advised Petitioner to remain off of work.

The records of those examinations catalog Petitioner's circumstances after he returned to work. His symptoms only got worse. He was having problems at work and off the job. He frequently reacted to irritants, despite trying to avoid them. Dr. Tuteur, concerned for Petitioner's health and safety, took Petitioner off of work due to his experiences on the job.

Closely related to his prompt return is the Commission's faulty conclusion that Petitioner was "quite active outdoors." Evidence of outdoor activities came from videos and testimony. From the testimony, it is obvious that Petitioner has suffered a dramatic change in lifestyle – on and off the job. That testimony was not disputed, and Respondent did not call anyone to challenge it.

The video evidence was created by Respondent's investigators, who surveilled Petitioner over four years. The videos show a lot of sedentary activity, like sitting and driving. For example, Petitioner drove to a restaurant drive-thru. He drove (or was driven) to medical appointments.

The videos also show Petitioner standing and slow walking. For example, he walks to his mailbox. Sometimes he walks with his oxygen, which is in his backpack.

The videos depict Petitioner sometimes putting on a mask before entering a building or pumping gas.

Frequent spot checks of the residence by the investigators usually yielded nothing. The surveillance proved definitively that Petitioner did not leave his house often, and when he did, it was not for long.

Respondent surveilled Petitioner in 2014, 2015, 2016 and 2017. There is no video of the Petitioner "speed" or "power" walking, jogging, running, hiking, biking, hunting, fishing, boating, shooting, climbing, swimming, skiing, lifting weights, bowling, going to a tavern, going to friends' or families' homes, going to a party, spending more than an insignificant amount of time shopping or eating inside a restaurant, mowing, weed-whacking, trimming, digging, gardening, painting, sealing, constructing, demolishing, cleaning, spraying, picking, cutting, burning, chain-sawing, working on a car or truck, working on a small-engine machine, metalworking, woodworking or washing anything.

The Commission refers to a video that depicts Petitioner attending an outdoor charity event sponsored by the Elks. In it, Petitioner removes two children's bikes from a pickup. The bikes are small.

He also commingles with the crowd, and at one point is near the BBQ and also near a smoker. The video speaks for itself. Petitioner testified he located himself so as to avoid triggering irritants. There was no testimony or evidence otherwise. He was near the BBQ and the smoke for a matter of minutes.

Far from being "quite active" as the Commission described him, the video proves that Petitioner was inactive. He spent his time in a sedentary position or else performing light/very light physical activity. Because there is un-impeachable proof of Petitioner's wide ranging, vigorous activity before the exposure, evidence of the dramatic change in activities and abilities after the

exposure supports Petitioner's claim of medical causation. It proves the first exposure was a watershed – and therefore a causative element. He was never the same after that first exposure.

The Commission incorrectly concluded Petitioner experienced only a temporary aggravation (of underlying asthma). That conclusion is belied by the fact that Petitioner has been under active treatment for a breathing problem ever since the first exposure. He has never not been under a doctor's care since the exposure. In the four years and nine months between exposure and trial, he worked only 8 months. That was the period immediately after the exposure - September through May, plus another three weeks before the second exposure. He did not return to work after the second exposure. He has been returned to work only by the Respondent's IME - no one else. In fact, the Respondent's own disability insurance examining doctor has found him unable to work as a result of this condition. Dr. Puricelli found that, without oxygen assisting his breathing, Petitioner's blood oxygen saturation falls to 91 within five minutes.

Finally, the Commission seemingly took no notice or account of Dr. Puricelli's opinion. She is one of four doctors who saw Petitioner. Dr. Roth (#1), the primary care physician since 1999, and Dr. Tuteur (#2) to whom Petitioner was sent by Corporate Claims, both believed the exposure(s) caused Petitioner's condition. Dr. Hyers (#3), the Section 12 examiner, did not. The Petitioner was also examined twice, however, by Dr. Puricelli (#4). She is Respondent's examiner for purposes of disability insurance. She twice found him unable to work, solely on the basis of his history of reactive airway disease (not asthma) and her own examinations. Her opinion deserved consideration, but was given none.

Conclusion

The Commission's erroneous fact-finding led it to several invalid conclusions. As a result, the decision is against the manifest weight of the evidence. The Commission's decision is therefore reversed. Cause is remanded for further proceedings.

So ordered.

Julie K. Katz
JUDGE

ENTERED: October 8, 2020

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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC029216
Case Name	MARTIN, DANIEL T v. CITY OF ROCKFORD
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0139
Number of Pages of Decision	21
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Thomas Duda
Respondent Attorney	Kevin Luther

DATE FILED: 4/12/2022

/s/ Kathryn Doerries, Commissioner

Signature

22IWCC0139

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNABAGO

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
X Modify 8.1 (b) factors, correct scrivener's errors	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DANIEL MARTIN,

Petitioner,

vs. NO: 15 WC 29216

CITY OF ROCKFORD,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, modifies the Arbitrator's decision, under Section 8.1b(b), factor (iv), on page 17, to strike the Arbitrator's language, and assign no weight to the factor as no evidence was presented as to a decrease in earning capacity.

The Commission, herein, modifies the Arbitrator's decision under Section 8.1b(b), factor (v) on page 17, where no weight assessment was made, and, adopting the Arbitrator's reasoning, assigns significant weight to the factor.

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision Order section, page 2, regarding weeks of permanent partial disability to replace "125 weeks" with "100 weeks".

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision, page 11 paragraph 1, last sentence, to replace "2013" with "2015".

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,153.85 per week for a period of 23-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 100 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 20% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $698.02 for medical expenses (reimbursement of out-of-pocket payments) under §8(a) of the Act.

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

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

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 12, 2022

o- 3/29/22
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

DECISION SIGNATURE PAGE

Case Number	15WC029216
Case Name	MARTIN, DANIEL T v. CITY OF ROCKFORD
Consolidated Cases	
Proceeding Type	
Decision Type	Corrected Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	19
Decision Issued By	Paul Seal, Arbitrator

Petitioner Attorney	Thomas Duda
Respondent Attorney	Kevin Luther

DATE FILED: 8/5/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 3, 2021 0.05%

/s/ Paul Seal, Arbitrator

Signature

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
CORRECTED ARBITRATION DECISION

Daniel T. Martin
Employee/Petitioner

v.

City of Rockford
Employer/Respondent

Case # **15** WC **29216**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Rockford**, on **May 20, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/21/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**90,000.00**; the average weekly wage was $**1,730.77**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **3** dependent children.

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

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

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

Respondent is entitled to a credit of $**36,548.08** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay to the Petitioner the sum of **$698.02** as reimbursement for the Petitioner's out-of-pocket payment of reasonable and necessary medical services rendered to him as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also be given credit as set forth above for the group health insurance payments made for the reasonable and necessary medical services documented in Petitioner's Exhibit 1; in accordance with Section 8(j) the Respondent shall hold the Petitioner harmless from any reimbursement claim or lien asserted by the group insurance carrier.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,153.85/week for 23 5/7ths weeks, commencing 7/21/2015 through 1/2/2016, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 125 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

AUGUST 5, 2021

FINDINGS OF FACT

I. Background - Petitioner's Employment

Petitioner Daniel T. Martin ("Petitioner" or "Martin") on the date of his accident, July 21, 2015, was a forty-one (41) year old firefighter/EMT hired by the Respondent, City of Rockford ("Respondent" or "City") on March 2, 2002 (Arb. Tr. 14); Martin became an EMT in 2008 (Arb. Tr. 15). Prior to his employment with Respondent, Petitioner had not worked for any fire department or private contracting ambulance and received no treatment of his low back. (Arb. Tr. 15). Upon his hiring by Respondent, Petitioner received and passed a physical exam which included range of motion exercises and a low back X-ray. (Arb. Tr. 15-16). After hire, Petitioner underwent yearly physical exams which included bending and twisting at the waist while wearing a respirator face mask, but not a complete physical. (Arb. Tr. 16-17). At the time of hire, Petitioner had no low back problems and received no treatment to his low back.

Martin's job duties were in the "Very Heavy" physical demand level. Petitioner testified that his duties when assigned to an engine and as a firefighter required him to wear bunker gear weighing 80 pounds plus an SCBA air tank weighing 30 to 40 pounds. (Arb. Tr. 17-18). He was also required to carry hoses of different sizes weighing from 80 to 100 pounds uncharged (without water). (Arb. Tr. 18-20). After pulling the hose off of the engine, he would advance the hose into the burning structure while crawling on his hands and knees. The diameter of the hose was between 1 ¾ inch and 2 inches and with water running through the hose, the weight increased considerably. (Arb. Tr. 18-20).

After the fire was extinguished, Petitioner testified that he then performed "overhaul" for up to several hours while wearing full gear and an air tank; overhaul required him to pull down the ceiling with a pipe pole, a tool between 4 and 10 feet in length with a hook on the end, using

an eight-pound axe to open up walls and open up floors. (Arb. Tr. 20-21). At times he was on a ladder truck where his duties were to set up ladders usually 20 but up to 35 feet in length and weighing up to 500 pounds, which was a two to three-person job while wearing all his gear and then carrying equipment weighing up to fifty pounds up the ladder. (Arb. Tr. 21-23). He also performed search and rescue while wearing full gear and air tank. (Arb. Tr. 23-24). He was required to attend yearly training exercises and preformed extrications in full gear and sometimes SCBA with tools weighing up to fifty pounds to free trapped patients and attend to patients. (Arb. Tr. 24-27).

Petitioner testified that as a paramedic he wore a standard uniform of regular clothes, safety glasses and gloves, not his turnout gear. (Arb. Tr. 27-28). For about 50% of these calls, he was required to move and lift patients using multiple tools including backboards and a gurney which was battery operated. (Arb. Tr. 28-29). On a normal twenty-four (24) hour shift he was assigned to the ambulance for twelve (12) hours responding to 6 to 10 medical calls per shift and to a fire apparatus for the other twelve (12) hours responding to at least one fire call and assist on the ambulance calls. (Arb. Tr. 27-32).

II. Petitioner's Accident of July 21, 2015

At the beginning of the hearing, the Respondent disputed whether Firefighter Martin suffered a work-related injury on July 21, 2015; at the conclusion of cross examination, the Respondent withdrew that dispute. (Arb. Tr. 56-57).

Petitioner testified that on July 21, 2015, he was assigned to a fire engine as part of the three-person team and responded to a lift assist. (Arb. Tr.31-32). Upon arrival he attended to an uninjured obese, over 300-pound, patient needing assistance into her recliner. (Arb. Tr. 33). Petitioner described the patient as a female bariatric patient who was on the floor wearing a lift

strap needing assistance to her recliner. (Arb. Tr. 33). While lifting the patient, she became unsteady and suddenly started to drop and the Petitioner instinctively held her upright to prevent her from falling and caught the weight of the patient as she went to the floor. The Petitioner and his crew were able to get her into a wheelchair without needing medical transport for her. (Arb. Tr. 34-35). Petitioner immediately felt a strain in his lower back, a 4 or 5 on the pain scale, but returned to the station and mentioned his condition to the officer for the NFIRS report and remained at the station for the duration of his shift. (Arb. Tr. 34-36; Px. 3). The records of injury reflect an assistance response and that the patient fell and needed to be held upright. (Px 2, Px 7, p. 5).

III. Petitioner's Medical Treatment

Petitioner testified that at the end of his shift at 8:00 am July 22, 2015, he went directly from the station to the Respondent's designated occupational health clinic, Marathon Health, an immediate care clinic, received an appointment for 2-3 hours later, so he showered at home and returned for the appointment with a nurse practitioner. (Arb. Tr. 35-37; PX 4 & 4A). According to the Marathon records, Martin was given pain medication, taken off shift until his follow up appointment on July 27, 2015, and then given an appointment to return in a week. (Arb. Tr. 37; PX 4A). He returned to Marathon on July 27, 2015, was examined and taken off of work until he was released by an orthopaedic surgeon. He was also referred to an orthopaedic surgeon, Dr. Roh of Rockford Spine Center. (Arb. Tr. 38). The records reflect Petitioner treated with Kristina Passarelli of Marathon Health on July 22 and 27, 2015 and she referred Martin to Dr. Roh for further treatment. (PX 4, p. 11, 13; PX 4A, p. 55-58). This referral was made on the second visit to Marathon, July 27, 2015, less than one (1) week after the July 21, 2015, accident. (PX 4 & 4A). Specifically, PA Passarelli made the referral to Dr. Roh with instructions that Firefighter Martin

was to be off duty "… until cleared by orthopaedic surgeon." (PX 4A – progress note – DOS – 07/27/2015).

Petitioner testified his first visit with Dr. Roh was on October 20, 2015. Prior to his October 20, 2015 visit, he received physical therapy at Rockford Spine Center consisting of core conditioning and stretching/traction. Petitioner had seen Dr. Roh for low back complaints before July 21, 2015. Petitioner sustained three (3) low back injuries at work which were treated by Dr. Roh. (Arb. Tr. 39-48; PX 14). Prior to the July 21, 2015 injury, Petitioner last treated with Dr. Roh on April 4, 2013.

Post-surgery, Petitioner received physical therapy at Rockford Spine Center and was subsequently release to full duty on January 2, 2016. (Arb. Tr. 49).

IV. Petitioner's Prior Treatment

Petitioner testified he treated with Dr. Roh in January 2011, following a work accident of December 31, 2010, and at that time described a left foot drop. (Arb. Tr. 39, 55). He also saw Dr. Minore with Medical Pain Management Services in 2011 and described low back pain and tingling down his left leg. (Arb. Tr. 53). In 2011, Dr. Roh treated petitioner with physical therapy and he was off work for two to three months. (Arb. Tr. 40). Petitioner could not recall if he received an epidural injection related to Dr. Rohs' 2011 treatment. (Arb. Tr. 40). Related to the December 31, 2010 accident Petitioner returned to work full duty. (Arb. Tr. 41). In the progress note of January 11, 2011, PA-C Matthew Schwabero stated that he discussed treatment options with Martin. (PX 6, p. 74-75). The patient and PA concluded that since Martin "does not have any pain, I probably would not recommend any further injections." Although surgery is mentioned as an option, it was never actually prescribed until October 2015. (PX 6, DOV: 01/11/2011).

Petitioner testified he sustained another work accident on August 13, 2012, to his low back and treated at Rockford Spine Center and Dr. Gahl. (Arb. Tr. 41, 54). In 2012, he described to Dr. Gahl he experienced pain and tingling in his left heel and had early left foot drop. (Arb. Tr. 54). He received three epidural injections in December 2012 and was off work for three months. (Arb. Tr. 42). After the injections he returned to work without permanent restrictions. (Arb. Tr. 42-43). In the closing progress note of November 9, 2012, Dr. Marie Walker released Martin to return to work without restrictions, but he advised him to use proper lifting techniques in order to avoid the risk of re-herniation or re-injuring his back. (PX 6, DOV: 11/09/2012).

Petitioner testified he sustained another work accident on February 22, 2013, moving a patient and treated with Dr. Roh and Dr. Walker. (Arb. Tr. 43). He did not receive treatment for his low back from April 4, 2013 until July 21, 2015 and during that period he worked full duty. (Arb. Tr. 44). The last visit with any medical provider at Rockford Spine Clinic occurred on April 4, 2013. This was the closing visit from the work accident of February 22, 2013. Michael Roh, M.D.'s medical conclusions are as follows:

> "Plan
>
> I explained to Mr. Martin that at this time he has the options of continued observation, physical therapy, epidural steroid injections or surgical intervention. However, given that his axial symptoms are well controlled at this time, I would not recommend anything different but I think the prognosis is good, so long as he takes calcium and has good nutrition he will likely eventually auto-stabilize the L5-S1 level and the discogenic pain should hopefully subside.

> Insofar as his neuropathic symptoms of radicular numbness, in the absence of pain I would not recommend any injections or surgery unless the numbness is progressive or associated with worsening neurological deficits such as weakness. On physical exam I cannot detect any weakness, though he does have a subjective sensation of weakness there." (PX 6, DOV: 04/04/2013).

No treatment was sought or rendered to Martin after April 4, 2013, until July 21, 2015, a period of over two and one-half (2 ½) years.

The records reflect Petitioner treated at Rockford Pain center with either Dr. Roh or Marie Walker, MD on January 1, 2011, September 17, 2012 through November 9, 2012, and on April 4, 2013. (PX 6, p 54-55, 62-66, 73).

Petitioner testified surgical options were discussed after the 2010 accident briefly and also the 2013 accident, but conservative treatment help relieved his issues other than some lingering pain. (Arb. Tr. 47-48, 54). The record reflects Dr. Roh did not recommend a surgical option in 2011. (PX 6, p. 120).

V. Petitioner's Current Condition

Petitioner testified when he returned to work in January 2016, he continued to experience pain that never completely went away, but that it was not debilitating. (Arb. Tr. 50). He stated he was more aware of how he performed physical activities and that he experienced pain across his low back and numbness and tingling in the thighs and feet and some weakness in his lower legs and feet into his thighs and that he walked more gingerly. (Arb. Tr. 50-51). He currently does not have any future medical appointments. (Arb. Tr. 55).

Petitioner last worked for the Respondent in 2017, but his departure is not due to his low back injury. (Arb. Tr. 49-50). .

Michael Roh, M.D.

Michael Roh, MD., a board-certified orthopedic surgeon, testified by evidence deposition. (PX 8, p. 5-6, Dep. Ex. 1). Dr. Roh's entire surgical case load is cervical, thoracic and lumbar surgery and he does not perform independent examinations. (PX 8, p.7). On November 9, 2015, Dr. Roh performed an L4-5 laminectomy and right-sided microdiscectomy and L3-4 laminectomy on Petitioner opined to a reasonable degree of medical and surgical certainty, that based on Petitioner's symptoms arising immediately following the July 21, 2015 work accident, the need for surgery was due to that accident. (PX 8, p. 15-16, 30-32). Dr. Roh provided two reports on the causation of Petitioner's treatment and condition. (PX 8, p. 22-23, Dep. Ex. 2, 3).

Dr. Roh first treated Petitioner on January 11, 2011 and diagnosed Petitioner with left lower extremity lumbar radiculopathy secondary to L3-4 and L4-5 herniated nucleus pulposus, treated the condition conservatively and Petitioner returned to work full duty. (PX 8, p. 8-10). In 2011 Dr. Roh's records noted footdrop which is caused by a problem in the lumbar spine. (PX 8, p. 30). Roh next saw Petitioner on April 4, 2013 after treatment by Dr. Walker, a physiatrist, complaining of more lumbar spine pressure and tingling in his thighs which was treated conservatively. (PX 8, p. 10).

Dr. Roh next saw Petitioner on October 20, 2015, when he presented with lower left extremity numbness, left foot lateral and plantar numbness, and balance issues, subsequent to a July 21, 2015, accident lifting a 400-pound person and took him off work. (PX 8, p. 11-12, 21, 25, Dep. Ex. 4). Dr. Roh was not aware of specific treatment in July of 2015; only some physical therapy and medication prior to October 20, 2015, and his patient's statement that his reported

symptoms were constant after July 21, 2015. (PX 8, p. 26, 28). Dr. Roh testified he conducted a sensation test of Petitioner's lower extremities which disclosed diminished sensation in the lateral and plantar aspect of the foot, reviewed X-Rays which disclosed significant disc height collapse at L4-5 and L3-4 and a bilateral sacralized L5 vertebrae and reviewed an MRI which showed disc herniation at L4-5, L5-S1 and L3-4. (PX 8, p. 12-13, 33-34). In 2015, Dr. Roh diagnosed Petitioner with L5 radiculopathy, prescribed conservative care and eventually performed surgery on November 9, 2015. (PX 8, p. 13-15). Dr. Roh agreed that he treated Petitioner prior to 2015 and that Petitioner had disc protrusions and stenosis prior to 2015 and had ongoing intermittent lumbar symptoms since 2011. (PX 8, p.26, 36). Dr. Roh testified that in 2015 the Petitioner had preexisting nerve root compression that was aggravated by trauma to the low back and that aggravation does not require a new discrete lesion for his causation opinion and also that the preexisting condition does not exclude the possibility of causality in this case. (PX 8, p. 39-40). Dr. Roh testified the surgery he performed was not necessary prior to July 21, 2015 because that patient was asymptomatic and did not meet the criteria for surgery until July 21, 2015. (PX 8, p. 40-41).

Dr. Roh testified he disagrees with the soft tissue lumbar strain diagnosis of Dr. Zelby because Petitioner's symptoms of numbness, which were quite pronounced and clearly neurological in nature, the fact that those symptoms could not in any way be caused by a simple soft tissue lumbar strain, and the fact that all Petitioner's prior symptoms resolved with conversative care. (PX 8, p. 18-19). Further, Dr. Roh testified Petitioner's need for surgery as caused by the work accident is corroborated by the resolution of Petitioner's numbness post-surgery and that he has not seen Petitioner since 2013. (PX 8, p. 19-20, 36).

Dr. Roh opined that Petitioner would not have been able to work as a firefighter between October 15, 2015, and December 28, 2015. (PX 8, p. 21-22).

Dr. Roh, was unequivocal in stating that there was a causal connection between the July 21, 2015, injury and the Petitioner's ultimate need for lumbar surgery at two (2) levels. (PX 8, p. 15-21; see also PX 8, deposition exhibits 2 and 3). In deposition exhibit 3, a letter dated April 15, 2019, Dr. Roh explains his disagreement with Dr. Zelby on the issue of causal connection. (PX 8). At the conclusion of his testimony, Dr. Roh reiterated his opinions on causation and affirmatively opined that surgery would not have been performed prior to the event of July 21, 2015, because Martin's symptoms did not meet surgical criteria until after the traumatic injury of July 21, 2015. (PX 8, p. 38-42).

Andrew Zelby, M.D.

Andrew Zelby, M.D., board certified in neurosurgery, testified by evidence deposition. (RX 7, p. 5; Dep. Ex. 1). Zelby testified he conducts four to eight worker's compensation IMEs each month 80% of the time for employers or insurance carriers. (RX 7, p. 44-45). Dr. Zelby testified that he never examined, never spoke to Petitioner and never read the imaging reports. (RX 7, p. 24-25). Dr. Zelby opined that Petitioner has a longstanding and preexisting degenerative condition that was already symptomatic and that the diagnostic studies prior to the July 2015 accident showed no progression of changes and there was no objective evidence that Petitioner's preexisting condition was altered from before July 2015, and that Petitioner reached MMI related to his July 21, 2015, accident at the latest by October of 2015. (RX 7, p. 14-16, 18-19). Zelby stated the Petitioner's need for the November 9, 2015, surgery was the result of his preexisting condition and previously recommended as a surgical option. (RX 7, p. 17). Zelby agreed with Dr. Roh's opinion that in 2011 the only reason to consider a surgical option was if there were progressive neurological deficits which Zelby agreed were not reflected in the 2011 records and that Dr. Roh indicated surgery was not recommended in 2011. (RX 7, p. 33, 43).

Zelby also agreed that Petitioner responded favorably to conservative treatment after his 2012 accident and returned to full duty. (RX 7, p. 34-35). Zelby further agreed that an individual with a degenerative spine condition would be more prone to injury, that he was not familiar with firefighting gear and that Petitioner received no treatment from his return to work in April 2013 until July 21, 2015. (RX 7, p. 28-29, 37, 42). In particular, Dr. Zelby stated "a degenerated spine is more prone to injury." (RX 7, p. 27-28).

CONCLUSIONS OF LAW

C. Regarding the disputed issue (C) on whether Petitioner's suffered an accident, the Arbitrator finds the following:

The Arbitrator finds that after the closing of proofs, Respondent withdrew its dispute regarding the July 21, 2015, accident. (Arb. Tr. 56). The petitioner met his burden of proving by a preponderance or the greater weight of the evidence that he sustained accidental injury arising out of and in the course of his employment with the respondent.

F. Regarding the disputed issue (F) on whether Petitioner's ill-condition is causally related to his exposures as a firefighter, the Arbitrator finds the following:

The Arbitrator finds that the petitioner's current condition of ill-being is causally related to the accident of July 21, 2015, which occurred in the course of Martin's employment with Respondent. The Arbitrator concludes that the July 21, 2015, accident caused the need for lumbar surgery and also exacerbated and aggravated Petitioner's pre-existing conditions in the low back, including disc herniation and degenerative disc disease. The Arbitrator's conclusion is based upon the credible testimony of the petitioner as to the events, the contents of the medical records from Marathon Health and Rockford Spine Center culminating in opinions on causation rendered by the treating orthopaedic surgeon, Michael Roh, M.D. The opinion of Dr. Roh on causation is well

documented in his evidence deposition as well as his letters to Attorney Duda on that particular issue. (PX 8 – Deposition Exhibit 2, 3).

The Arbitrator credits the opinions of Dr. Roh over those of Dr. Zelby for a number of reasons. Dr. Roh is in a better position to assess causal connection than Dr. Zelby. Dr. Roh knew the entire history of low back pathology relating to Daniel Martin. Dr. Roh's familiarity with Martin's medical condition dated back to January 11, 2011, and he was intimately familiar with the past history, pain complaints and symptoms experienced by Martin from 2011 through 2015. The Arbitrator is aware that there were positive radiological findings of disc herniation before July 21, 2015. In Dr. Roh's progress note of January 11, 2011, he interprets an MRI performed a year earlier and notes that sagittal images reveal disc herniations at the L3-4 and L4-5 levels and that Martin has some mild bilateral L4-5 foraminal stenosis. (PX 6; DOV: 01/11/2011). Despite these radiological findings, Dr. Roh successfully treated the Petitioner's symptoms conservatively. Notwithstanding the radiological findings, Martin responded to conservative care and received a series of three (3) epidural injections and reported on April 4, 2013, that he was not experiencing pain. Further, as Dr. Zelby noted, an individual with a degenerative spine condition is more prone to injury. (RX 7).

Also, Dr. Roh's opinions were given in a straightforward and unequivocal manner without reservation. There is no question that the July 21, 2015, accident was the cause of Petitioner's need for lumbar surgery and his current state of disability.

J. Regarding the disputed issue (J) on whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent paid all appropriate charges for the reasonable and necessary medical services; the Arbitrator finds the following:

Having concluded the Petitioner's condition of ill-being related to his accident of July 21, 2015, while working for Respondent, the Arbitrator finds that the medical treatment sought by Petitioner from July 21, 2015, through the present was reasonable and necessary. The Arbitrator finds that the bills in Petitioner's Exhibit 1 are related to Petitioner's claim and are attributed to Respondent. The Respondent is liable to reimburse the Petitioner his out-of-pocket expenditures of $698.02 and the Respondent is entitled to credit for group insurance payments totaling $36,548.08, pursuant to Section 8(j).

K. Regarding the disputed issue (K) on whether the Petitioner is entitled to TTD for the period 7/21/2015 through 1/2/2016, the Arbitrator finds the following:

The Arbitrator concludes that Martin was taken off of work pending an evaluation by an orthopaedic surgeon on his first visit to Marathon Health, the employer's occupational health clinic. Dr. Roh never released the Petitioner to return to work until after the physical therapy performed post-surgery on January 2, 2016. The Petitioner is owed $1,153.85 per week for 23 5/7ths weeks covering the period of temporary, total disability for the period from July 21, 2015 through January 2, 2016.

L. Regarding the disputed issue (L) on the nature and extent of the Petitioner's injury, the Arbitrator finds the following:

The Arbitrator renders the following determination of permanent partial disability in accordance with the factors outlined in 820 ILCS 305/8.1b.

Section 8.1b(b)

(i) Since neither party submitted an AMA impairment rating report, the Arbitrator gives no weight to that factor in determining permanent partial disability.

(ii) The Arbitrator gives great weight to the impact of the disability documented in the medical records in regard to the established occupation of the Petitioner. The Petitioner at the time of his accident was a thirteen (13) year veteran on the Rockford Fire Department. Although Martin did return to his pre-injury occupation, he credibly testified to documented complaints of continuing low back pain with numbness, tingling and weakness that never completely went away. His low back and extremity problems did not prevent him from continuing in his usual and customary occupation but, given the heavy and very heavy nature of his duties, these manifestations of disability would be significant. He would note pain of 2 out of 10. He became more aware of his pain with activities that he was performing including walking and carrying things. He did have some numbness and tingling in his thighs and feet and some weakness. These post-surgical complaints would be more disabling to an injured employee engaged in a very heavy occupation like that of the Petitioner.

(iii) The Arbitrator gives great weight to the age of the employee on July 21, 2015. He was only forty-one (41) years of age at the time. A very young employee in the middle of an established career.

(iv) The Arbitrator gave some, but not a significant amount of weight to the Petitioner's future earning capacity. No direct evidence of any direct impact on Martin's future earning capacity was offered. However, at the age of forty-one (41) with four (4) low back injuries, the most recent of which led to surgery, it would not be speculative that some impact on future earning capacity could result from the July 21, 2015, accident.

(v) The evidence of disability is corroborated extensively throughout the treating medical records of the Petitioner. The medical records present objective evidence of a pre-existing condition which was materially aggravated by a lifting episode if a bariatric patient on July 21, 2015. The surgery performed on the Petitioner was not a simple one level laminectomy. The operative report contained in Petitioner's Exhibit 5, documents a multi-level lumbar surgery. In particular, Dr. Roh performed an L3-4 open lumbar laminectomy with a medial facetectomy and foraminotomy. At L3-4 Dr. Roh also performed a right sided microdiscectomy.

Surgery at a second level, L4-5 was also performed with an open lumbar laminectomy, medial facetectomy, foraminotomy. Such a multi-level surgery could readily account for the Petitioner's complaints of chronic pain upon returning to his usual and customary occupation.

Despite the fact that the July 21, 2015, injury and its consequence surgery did not end the Petitioner's career, the Arbitrator believes that a 20% loss to the body as a whole, based on the above factors, is the appropriate permanent disability award to be rendered in this case.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC017723
Case Name	HALL, STEPHEN v. DR PEPPER SNAPPLE GROUP
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0140
Number of Pages of Decision	15
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Luis J. Magaña
Respondent Attorney	Matthew Novak

DATE FILED: 4/12/2022

/s/Christopher Harris, Commissioner

Signature

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

STEPHEN HALL,

Petitioner,

vs. NO: 18 WC 17723

DR. PEPPER SNAPPLE GROUP,

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 care, temporary total disability (TTD) benefits, maintenance benefits and vocational rehabilitation, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

The Commission first extends the TTD period through November 9, 2020. On this date, Petitioner underwent the valid functional capacity evaluation which placed him in the light physical demand level and provided the parameters of his permanent restrictions. The Commission next agrees that Petitioner is entitled to vocational rehabilitation and affirms the Arbitrator's Decision in this regard. However, Petitioner's entitlement to maintenance benefits began once he engaged in vocational rehabilitation services on February 3, 2021. The Commission therefore strikes the Arbitrator's award of maintenance benefits from November 9, 2020 through August 11, 2021 and modifies the Decision to state that Petitioner is entitled to maintenance benefits from February 3, 2021 through August 11, 2021.

Section 8(a) of the Act provides: "The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." *820 ILCS 305/8(a)*.

> Since maintenance is awarded incidental to vocational rehabilitation, an employer is obligated to pay maintenance only 'while a claimant is engaged in a prescribed vocational-rehabilitation program.' (Citation omitted). 'A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will increase his earning capacity.' (Citation omitted). Because the primary goal of rehabilitation is to return the injured employee to work (citation omitted), if the injured employee has sufficient skills to obtain employment without further training or education, that factor weighs against an award of vocational rehabilitation. *National Tea Co. v. Industrial Comm'n*, 97 Ill. 2d 424, 432, 454 N.E.2d 672, 73 Ill. Dec. 575 (1983). Moreover, an injured employee is generally not entitled to vocational rehabilitation if the evidence shows that he does not intend to return to work, although able to do so. (Citation omitted). Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising job search programs, and vocational retraining, which includes education at an accredited learning institution. (Citation omitted). An employee's self-directed job search or vocational training may constitute a vocational-rehabilitative program.

Euclid Bev. v. Ill. Workers' Comp. Comm'n, 2019 IL App (2d) 180090WC ¶ 29-30.

The Commission finds no evidence that Petitioner participated in either a vocational rehabilitation program or a self-directed job search from November 10, 2020 through February 2, 2021. The record instead demonstrated that Petitioner first met with Edward Pagella of Health Connection of Illinois on February 3, 2021 for an assessment and thereafter proceeded with vocational rehabilitation services through the date of arbitration. Pursuant to Section 8(a) of the Act, the Commission finds that Petitioner is entitled to maintenance benefits from February 3, 2021 through August 11, 2021 and modifies the maintenance period accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed September 21, 2021, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $685.88 per week for a period of 110 4/7 weeks, commencing September 28, 2018 through November 9, 2020, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $5,154.45 for temporary benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner maintenance benefits of $685.88 per week for a period of 27 1/7 weeks, commencing February 3, 2021 through August 11, 2021, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for vocational rehabilitation services, including all maintenance costs and expenses incidental thereto, pursuant to Section 8(a) of the Act.

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

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

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

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

April 12, 2022

CAH/pm
O: 4/7/2022
052

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

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC017723
Case Name	HALL, STEPHEN v. DR PEPPER SNAPPLE GROUP
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b)/8A Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	12
Decision Issued By	Carolyn Doherty, Arbitrator

Petitioner Attorney	Luis J. Magaña
Respondent Attorney	Matthew Novak

DATE FILED: 9/21/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 21, 2021 0.04%

/s/Carolyn Doherty, Arbitrator

Signature

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/8A

Stephen Hall
Employee/Petitioner

v.

Dr. Pepper Snapple Group
Employer/Respondent

Case # **18** WC **17723**

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 **Doherty**, Arbitrator of the Commission, in the city of **Joliet**, on **8/11/21**. After reviewing all 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 **vocational rehabilitation**

FINDINGS

On **12/28/17**, 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 $**53,499.16**; the average weekly wage was $**1,028.83**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **4** 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** for TTD, $**5,154.45** for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**5,154.45**.

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

ORDER

Respondent shall pay Petitioner temporary total disability of $685.88 per week for the period of 110-3/7 weeks commencing 9/28/2018 to 11/8/2020. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner maintenance of $685.88 per week for a period of 39-3/7 weeks commencing 11/9/2020 to 8/11/2021.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall authorize and provide Petitioner with vocational rehabilitation services through the date of hearing and continuing thereafter.

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

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

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

Carolyn M. DeCrecy

Signature of Arbitrator

SEPTEMBER 21, 2021

FINDINGS OF FACT

This matter proceeded to trial on August 11, 2021. The issues in dispute were causal connection, medical bills, TTD benefits, Maintenance benefits and entitlement to vocational rehabilitation services. ARB EX 1.

Petitioner was employed as a sales and service representative for Respondent. Petitioner testified that he sold the product and filled the shelves himself by lifting cases of pop and smaller bottles of Snapple during his shift. On the date of the undisputed accident 12/28/17, Petitioner was pulling a pallet of pop when he stepped back and felt an immense amount of pain in his right foot. Petitioner testified he reported the accident right away and was sent to a clinic in Indiana.

On December 28, 2017 Petitioner presented to the Working-Well Franciscan Hammond Clinic. Petitioner was a 34-year-old male who presented with a right foot injury. He noted he was pulling a pallet of soda in the aisle of the store and felt/heard a pop in his right foot. (PX 15). X-rays were normal. Petitioner was administered a Toradol injection and was diagnosed with an acute right foot sprain. Petitioner was provided restrictions of no driving, elevation of the foot and a seated job. (PX 15).

In a January 10, 2018 follow up Petitioner noted he was better. Petitioner was ordered an MRI of the right foot. Petitioner underwent the MRI on January 18, 2018 that revealed mild degenerative changes, thickening and increased signal intensity consistent with a Lisfranc ligament sprain and possible Baxter's neuropathy. (PX 3). In a January 23, 2018 follow up it was noted that Petitioner's MRI of the right foot showed a Lisfranc ligament sprain and Baxter's neuropathy abductor digiti minimi muscle. (PX 15). Petitioner was referred to Podiatry.

Petitioner presented to Advanced Foot and Anklet Centers of Illinois on January 31, 2018 and was seen by Breck Tiernan, DPM. (PX 17). Petitioner complained of right heel pain noting that it was localized in the medial aspect of the heal. Petitioner was diagnosed with plantar fasciitis of the right food and neuritis. He was provided Ibuprofen, a Medrol Dosepak and Tylenol and provided an injection into the right heel. (PX 15). He was off work. Petitioner returned on February 7, 2018 with right heel pain. Petitioner underwent therapy and treatment with no progress. As of February 22, 2018, Petitioner was provided orthotics and was to continue to therapy. (PX 15).

In a March 15, 2018 follow up Petitioner stated he felt like he had a nerve type pain and therapy had been ineffective thus far. He noted he could not stand on his foot for longer than 15 minutes without pain. Petitioner was still diagnosed with plantar fasciitis of the right foot, neuritis and was now diagnosed with tarsal tunnel syndrome of the right lower limb. Petitioner was to undergo an EMG and remain off work. (PX 15).

In an April 15, 2018 follow up Petitioner was still experiencing nerve pain in the right heel but also felt it in the left heel. Petitioner stated he had times of burning, tingling and numbness in different areas of his body. Petitioner was referred to pain management for possible CRPS. On April 26, 2018 Petitioner's underwent an EMG/nerve conduction study which was normal. (PX 15).

Petitioner followed up on May 3, 2018 and noted his NCV test revealed no abnormalities. Petitioner was recommended physical therapy for four weeks. Petitioner began physical therapy on May 4, 2018 (PX 16). Petitioner was to undergo therapy two times a week for six weeks. As of May 17, 2018, Petitioner noted he started to develop ankle pain while ambulating. In a May 31, 2018 follow up Petitioner noted he was developing new pains in his feet which were getting worse. He also had unexplained swelling. Petitioner was once again advised to obtain a consultation with a pain management physician. (PX 15). Petitioner was discharged from therapy on June 1, 2018 as he was recommended to be seen by a pain specialist for CRPS. (PX 16). Petitioner was last seen by Tiernan, DPM, on June 21, 2018. Petitioner continued to have nerve pains in his legs and feet. Petitioner was recommended to see a pain specialist once again. (PX 15).

On June 14, 2018 Petitioner presented to Dr. Bryan Ho from Hinsdale Orthopaedics. (PX 18, PX 3). Petitioner was a 35-year-old male who presented for bilateral foot pain. Petitioner noted that his injury was over six months ago and occurred to his right foot. Petitioner noted his burning type pain began approximately four months ago over his right leg as well over the top of his foot. The doctor reviewed the MRI and diagnosed Petitioner with CRPS that was likely secondary to his work injury and right tarsal tunnel syndrome. Petitioner was to begin physical therapy, gabapentin and see a pain specialist. Petitioner was off work (PX 18). On June 26, 2018 Petitioner began physical therapy at ATI Physical Therapy presenting with signs and symptoms of CRPS. Petitioner was to undergo therapy three times a week for six weeks. (PX 16).

On June 28, 2018 Petitioner presented to Dr. George Holmes of Midwest Orthopaedics at Rush for an Independent Medical Evaluation. Dr. Holmes reviewed medical records and performed a physical exam on Petitioner. He noted Petitioner had increased sensitivity to light touch which was circumferential in nature. Dr. Holmes noted Petitioner's diagnosis appeared to be absence of any specific orthopaedic injury. There was no evidence of a Lisfranc injury or structural injury. From an Orthopaedic standpoint, his prognosis was excellent. Dr. Holmes further indicated he would defer on confirmation of the diagnosis of CRPS to a neurologist, a physiatrist or pain management physician. From an Orthopaedic standpoint Petitioner could return to work full duty and was at maximum medical improvement. (RX 1).

On July 10, 2018 Petitioner presented to Dr. Farooq Khan as a referral by Dr. Ho for an evaluation and treatment of bilateral foot pain and lower extremity pain. Petitioner complained of significant pain in the right foot with additional left foot pain radiating up into the lower extremities. He also complained of diffuse myofascial pain in the neck, back and upper extremities. Petitioner was diagnosed with a right tarsal tunnel syndrome in the right lower limb, Complex regional pain syndrome I (CRPS) of the right lower limb, pain in the right foot, pain in the left foot and myofascial pain (PX 11). Petitioner was advised to utilize over the counter medications until the Section 12 report was received.

Petitioner returned to Dr. Khan on August 6, 2018 for his bilateral foot pain. Petitioner was to follow up with Dr. Ho and continue with desensitization therapy. On September 6, 2018 Petitioner was discharged from therapy as he had not shown any significant improvement. (PX 16). Petitioner returned on September 10, 2018 to Dr. Khan with reports of swelling, redness, burning and allodynia in his feet, right greater than left. Petitioner was recommended lumbar sympathetic plexus nerve blocks and was off work. (PX 11).

On August 21, 2018 Petitioner presented to Dr. Kenneth Candido for a Section 12 examination (RX 2, Exhibit 2). Dr. Candido examined Petitioner and reviewed the medical records. Petitioner noted that his pain was a six out of ten at rest and increased to a nine out of ten with activity. Dr. Candido opined Petitioner did not have complex regional pain syndrome. He further noted that the condition of cerebral palsy was not an issue for CRPS as Petitioner did not have this condition. Dr. Candido did diagnose Petitioner with fibromyalgia but could not relate it to his work injury. In regard to his right foot injury, Petitioner was able to work full duty and was at maximum medical improvement. (RX 2, EX. 2).

On September 13, 2018 Petitioner returned to Dr. Ho. It was noted Petitioner was able to ambulate without any assistive devices. Petitioner still complained of burning and swelling. Physical therapy had not helped. Petitioner was to continue with treatment with Dr. Khan. Petitioner was off work. (PX 3).

On October 13, 2018 Petitioner underwent the lumbar selective nerve root block with Dr. Khan. (PX 11).
In an October 29, 2018 follow up Petitioner noted he sustained 80% relief for the last five days. Petitioner received a second lumbar selective nerve root block on this date. (PX 11).

On November 26, 2018 Petitioner returned to Dr. Khan for his bilateral foot and lower extremity pain. Petitioner noted 80% relief from the lumbar sympathetic plexus block for nearly two weeks after the injection. Petitioner continued to require a cane for ambulation and remained off work due to injury. Petitioner was provided medication and advised to follow up with Dr. Ho. (PX 11). Petitioner returned to Dr. Ho on December 13, 2018. Petitioner described his pain as a 7 out of 10. Dr. Ho disagreed with the Section 12 examiner noting Petitioner continued to have symptoms and pain consistent with complex regional pain syndrome. Petitioner was to treat with Dr. Khan. (PX 3).

In a December 17, 2018 follow up Petitioner was complaining of left leg weakness over the weekend with heavy lifting. Petitioner was provided another lumbar selective nerve root block. (PX 11).

Petitioner returned on January 21, 2019. Petitioner reported allodynia and noted pain when wearing pants. He also noted increased burning sensation and swelling in the bilateral lower extremities. Petitioner also reported left lower extremity weakness that caused multiple near falls which required the assistance of a cane with ambulation due to his symptom. Petitioner also noted increased dry skin with redness and itching in the lower legs. Petitioner was to follow up with Dr. Ho and consider a spinal cord stimulator trial. (PX 11).

On March 4, 2019 Petitioner followed up with Dr. Khan. Petitioner continued to note burning, dry skin and redness in the lower leg as well as swelling, allodynia and intermittent spasms in the bilateral feet. Petitioner was diagnosed with complex regional pain syndrome I (CRPS) of the right lower limb and was referred to a psychologist for a psych clearance for a spinal cord stimulator trial. Petitioner was to return. (PX 11).

On March 28, 2019 Petitioner returned to Dr. Ho. Petitioner was to continue with pain management and wait for approval of the spinal stimulator trial. Petitioner remained off work. (PX 3). Petitioner returned to Dr. Ho on May 30, 2019. Petitioner noted that his CRPS was worsening. He now needed assistance with ambulation to include a cane. Petitioner wanted to assess what his options were besides a spinal cord stimulator. Petitioner was referred to Dr. Lubenow at Rush for evaluation.

On July 25, 2019 Petitioner first presented to Dr. Lubenow. Petitioner was a 36-year-old male with history of cerebral palsy, a work related injury (12/28/17), bilateral foot/lower extremity pain, myofascial pain and CRPS (right lower extremity), who presented as a referral for work up of neuropathic pain after a work related injury. Dr. Lubenow noted Petitioner did not meet the full criteria for CRPS of the lower extremity. Based on the same exam, Petitioner was likely suffering from small fiber neuropathy. Petitioner was provided Topamax and was to return in a month for a skin punch biopsy. (PX 14).

Petitioner returned to Dr. Ho on August 8, 2019. Petitioner was schedule for a skin biopsy to evaluate for small fiber neuropathy. Petitioner remained off work. (PX 3).

On August 21, 2019 Petitioner returned to Dr. Lubenow for a one month follow up. He presented today for a skin punch biopsy. Petitioner was diagnosed with neuropathic pain and was to return. (PX 14) The pathology report from the skin punch biopsy revealed skin with significantly reduced Epidermal Nerve Fiber Density, consistent with small fiber neuropathy, in the right proximal arm, right distal arm, right thigh, right calf and right foot. (PX 12).

On September 19, 2019 Petitioner presented to Dr. Lubenow. It was noted that Dr. Lubenow placed Petitioner on Topamax which improved his muscle twitching/spasms. Dr. Lubenow reviewed his skin punch biopsy results which showed significantly reduced epidural nerve fibers consistent with small fiber polyneuropathy. Petitioner was diagnosed with neuropathic pain and small fiber polyneuropathy. Dr. Lubenow recommended a medical management, if he failed with the same, they would consider a spinal cord stimulator trial. (PX 14).

Petitioner returned to Dr. Ho on September 26, 2019. Dr. Ho noted that the punch biopsy confirmed small fiber neuropathy. Dr. Ho was deferring further treatment to Dr. Lubenow. He remained off work and would follow up as needed. (PX 3).

On October 16, 2019 Petitioner followed up with Dr. Lubenow. Petitioner was prescribed Cymbalta but had to stop taking the same due to side-effects. Petitioner was scheduled for a Boston spinal cord stimulator on November 18, 2019. Petitioner was also recommended to stop smoking. Petitioner was to see Dr. Merriman prior to the procedure. (PX 7).

On November 18, 2019 Petitioner underwent a trial implantation of a stimulator trial with cervical and lumbar leads. (PX 7).

On November 21, 2019 Petitioner followed up with Dr. Lubenow. Petitioner presented for his first post-procedural follow up. Petitioner was to return on November 25, 2019 to assess the efficacy. (PX 7).
Petitioner followed up with Dr. Jaycox on November 25, 2019 at Rush Pain Center for his second post-procedural follow up. The doctor noted it was a successful spinal cord stimulator trial and would move forward with a permanent placement. Petitioner was encouraged to stop smoking. (PX 7).

On January 6, 2020 and January 13, Petitioner underwent a permanent stimulator. (PX 6).

Petitioner followed up on February 27, 2020 with Dr. Lubenow. It was noted Petitioner had a placement of the Boston SCS on January 6, 2020 and January 13, 2020. Petitioner reported 50% pain relief since placement. Petitioner was provided Topamax and was to follow up. (PX 6).

Petitioner followed up on May 6, 2020 with Dr. Lubenow. Petitioner now noted only a 40% reduction in pain. Petitioner was to continued Topamax and would require re-programming.

On July 16, 2020 Petitioner follow up with Dr. Lubenow. Petitioner had improved with ADLS and was able to complete laundry and drive 90 minutes without issues. Petitioner's SCS was reprogrammed and medication filled. (PX 2).

On June 29, 2020 Dr. Candido authored an addendum report. He noted that Petitioner may have small fiber neuropathy but this was consistent with his original diagnosis of fibromyalgia. The mechanism of allegedly injury was not related to the small fiber peripheral neuropathy. He noted that there are no known causes for most cases. Diabetes mellitus and impaired glucose tolerance were the most common diseases that lead to this disorder. There was no association between small fiber polyneuropathy and any alleged mechanism of injury in this case. He noted that that the condition of small fiber polyneuropathy was due to a pre-existing, underlying condition of fibromyalgia. (RX 3).

In an October 8, 2020 follow up Petitioner noted good pain control. Petitioner had now reached maximum medical improvement and was to undergo an FCE. (PX 2).

Petitioner underwent a FCE on November 9, 2020. On December 9, 2020, the FCE was amended and revealed that the FCE to be valid. It was noted Petitioner was able to work light duty consisting of a four hour work day. Within that work day, Petitioner could sit for a 45 minute duration with breaks, stand 1-2 hours in 15 min durations and walk 2-3 hours, occasional with short distances. (PX 9).

On December 10, Petitioner followed up with Dr. Lubenow via a telehealth visit. Petitioner's pain was reduced by 50% and was a four out of ten. The FCE was valid and demonstrated Petitioner able to complete light duty work with a lifting restriction of 20 lbs. Petitioner was released to light duty work with a lifting restriction of 20 lbs. (PX 2).

Testimony

On February 22, 2019 Dr. Farooq Khan testified via evidence deposition. PX 10. Dr. Khan is a board-certified pain management physician. Dr. Khan testified that he treats complex regional syndrome (CRPS) which is a central processing issue in which pain develops not necessarily from an anatomic pattern but where the nerve itself becomes problematic in that it is sensitized. (PX 10, p. 6, 7). Dr. Khan testified to Petitioner's work accident and medical care as outlined in his medical records. He further noted that when he examined Petitioner he saw edema, erythema (redness), slight atrophy (shrinking/loss of muscle mass), and limited range of motion. (PX 10, p. 13-14). Dr. Khan noted that Petitioner was limited in all panes of motion equally, any direction or movement caused pain. He was also limited in strength because he was so sensitive and had increased sensation to light touch with tenderness to palpation. These were all part of the clinical picture of CRPS. (PX 10, p. 14-15). Based on the same, Dr. Khan felt Petitioner was exhibiting signs and symptoms of CRPS at his first visit. He did note that Petitioner's complaints were more diffuse, to include his opposite foot and hips which did not fit into a diagnosis of CRPS. (PX 10, p. 18).

Dr. Khan testified that he eventually recommended lumbar sympathetic plexus block series which were both diagnostic and therapeutic interventions. Essentially, the lumbar spine is targeted, specifically the sympathetic nerves which are responsible for the sensations such as hot and cold, buzzing, venous dilation or constriction. (PX 10, p. 22). He explained when they block those nerves there should be improvement in the symptoms. The downside is that it can last up to eight hours to a day at most and eventually the symptoms come back. The theory is each time you shut off the nerve the hope is that when they restart they restart at a lower level than they were before. (PX 10, p.23). Dr. Khan noted that although the first two injections provided temporary relief to Petitioner the third injection did not. Dr. Khan's diagnosis was still CRPS based on the face he had persisting allodynia and the fact he benefited from lumbar sympathetic plexus block. He also noted he appearance of his foot changed. To a reasonable degree of medical certainty Dr. Khan diagnosed Petitioner with CRPS. (PX 10, p. 30). Dr. Khan further advised that this was related to work based on the medical records and Petitioner's own history of a lack of any such symptoms prior to his work accident. PX 10, p, 30-31. He did qualify that he did not see Petitioner prior to the injury. He also noted that Petitioner did not seem untruthful although did have a lot of myofascial pain complaints. (PX 10, p. 31).

He further testified that he did not believe Petitioner had fibromyalgia and if he did, he would have referred him to a rheumatologist. (PX 10, p. 32). Dr. Khan testified that he recommended a spinal cord stimulator as well. If Petitioner responded well to the same, he would recommend a permanent implantation with a subsequent FCE. If Petitioner did not respond to the same, he would not recommend a permanent implantation. He noted Petitioner would need ongoing physical therapy one to two times a year for desensitization. In between flare ups, he should be functional. (PX 10, p. 36-37). Dr. Khan noted that Petitioner had more of a waxing-and-waning clinical picture. As such, depending on activity, his symptoms may come and go. (PX 10, p. 52). He noted he did not do any tests to test for fibromyalgia. Petitioner was also diagnosed with myofascial pain not fibromyalgia. But he did note that fibromyalgia is not the type of syndrome or disease seen developing after an injury. (PX 10).

On April 30, 2019 Dr. Candido, Respondent's Section 12 examiner testified on this matter. Dr. Candido is board certified specializing in pain management. (RX 2, p. 9). Dr. Candido testified he spends roughly an hour conducting the examination and five to ten hours reviewing materials and preparing the report (RX 2, p. 9). The doctor went over the medical records he reviewed and the accident history (RX 2, p. 11). Dr. Candido testified that Petitioner had fibromyalgia, a systemic condition, and not complex regional pain syndrome. He noted that he did not meet any criteria for consideration of CRPS by virtue of not having any asymmetry, no temperature disparities, no color changes, no edema, no atrophy, no severe pain to light touch, no evidence of a sweating abnormality or a blood flow abnormality, no trophic signs including no hair or nail growth, no tremors, and no obvious weakness. (Rx 2, p, 16-17). He noted that he has lectured on fibromyalgia many times and treated the condition. Dr. Candido further noted Petitioner's fibromyalgia was not work related. He testified that "…there was no indication that a potential crush injury to a distal area of one part of the body could potentially lead to a systemic condition where there's bilaterality including pain, full symptoms in the neck area, the shoulder area, the upper extremities, the torso, the back." (RX 2, p. 20). He noted he never has seen an isolated foot injury that leads to fibromyalgia. He further noted Petitioner was at maximum medical improvement and did not require work restrictions. (RX 2, p. 21).

On June 10, 2020 the parties proceeded with the deposition of Dr. Timothy Lubenow. Dr. Lubenow is the director for the section of pain medicine at Rush University focusing on pain management (PX 8, p. 5). Dr. Lubenow testified to Petitioner's history of work accident and medical care as outlined in his medical records. Dr. Lubenow testified that the skin punch biopsy is the most sophisticated test that they can do to evaluate for the presence of neuropathy which affects the very small nerve fibers in an extremity. (PX 8, p. 11). Dr. Lubenow testified Petitioner had a neuropathic pain that was due to small fiber neuropathy which was not the same as CRPS. Neuropathic pain emanates from disease, damage or dysfunction of the nervous system (PX 8, p. 13). He noted that "the small nerve fibers can also be injured by trauma, at which point it sets a neuropathic pain condition to be started in that injury extremity." PX 8, p. 14. This can be confused with CRPS (PX 8, p.14). He went on to differentiate the two. Small fiber peripheral neuropathy is a disease of peripheral nervous system that starts at some point in time, that usually has a very slow genesis and slow progression such that patients may remain asymptomatic for years. Peripheral neuropathy is a condition that is more commonly seen. Small fiber peripheral neuropathy is typically in an older age group. However, if those nerves that are vulnerable to irritation or injury get injured because of some surgery or trauma, it sets into motion the neuropathic pain condition to

become manifest shortly after that antecedent injury. It is because that injury caused this aggravation of the small fiber peripheral neuropathy (PX 8, p.15-16).

He further testified that CRPS is one of the neuropathic pain conditions. It can also start with trauma or surgery but has some other antecedent events, CRPS has to do with a nerve injury then causes damage to the sympathetic nervous system. CRPS has a poorer prognosis and gives rise to a greater degree of motor dysfunction, muscle dysfunction, weakness and tremor. Dr. Lubenow testified that he diagnosed him with small fiber neuropathy in partial from the skin punch test. He noted that he took biopsies from five different places and all came back with the same diagnosis, significantly reduced epidermal nerve fiber density consistent with small fiber neuropathy. (PX 8, p. 18). He noted that even though his arm was not injured he had complaints of pain and had the same type of small fiber neuropathy as the lower extremity. In Petitioner's case, if this was CRPS they wouldn't see small fiber peripheral neuropathy in the thigh or the arms at all. Dr. Lubenow further concluded this was related to Petitioner's work injury as Petitioner had no complaints of pain in the right lower extremity prior to the injury. The second basis is that Petitioner had an injury to the right lower extremity while pulling the pallet jack, and this is the type of injury he has seen patients develop an aggravation of small fiber peripheral neuropathy. (PX 8, p. 21). He indicated Petitioner likely had this asymptomatic condition that was aggravated with the work injury of December 2017. He concluded that the initial injury was him feeling a pop in the bottom of his foot but also strained to the tibial nerve that aggravated the small fiber neuropathy.

Dr. Lubenow advised that he treated this condition with medication. If there is no response, he would recommend a trial of a spinal cord stimulator which Petitioner received (PX 8, p. 22). Dr. Lubenow noted he usually would advise Petitioner to stay off work during the trial. His usual custom and practice is to send patients for a course of physical therapy for six weeks and then allow a return back to work. (PX 8, p. 23). Dr. Lubenow testified that he did not see any specific comments one way or the other regarding work issues. (PX 8, p. 24). Dr. Lubenow noted that patients are seen at a time frame when they reach maximum medical improvement three months post stimulator implant and then a release to work within restrictions of an FCE. (PX 8, p. 28). He was not precluding him to return to work in some capacity. (PX 8, p. 43).

Dr. Lubenow further testified that he did not test Petitioner for fibromyalgia as his condition was not consistent with the same. (PX 8, p. 34). In addition, Petitioner's cerebral palsy, obesity and the fact he was a smoker did not change his causation opinion (PX 8, p. 44). Dr. Lubenow could not point to any specific literature for the basis of his opinions. (PX 8, p.48).

Vocational Testimony

Certified Rehabilitation Counselor Ed Pagella, president of Health Connection of Illinois, prepared an Employability Study after meeting with Petitioner on February 3rd and 17th, 2021. Mr. Pagella opined Petitioner had obtained sales and customer service skills and had excellent mechanical skills which would transfer over to sales positions or a photo lab technician. He also noted Petitioner would have a difficult time finding work due to FCE restrictions but recommended vocational rehabilitation to assist him with the same. (PX 5). Mr. Pagella testified on June 30, 2021. He noted that per Petitioner's FCE Petitioner was able to sit for four hours at 45-minute durations and stand one to two hours at 15 minute durations and occasionally walk two to three hours. The report indicates Petitioner can work at the light level of physical tolerance with occasional usage of activities such as grasping and fine finger manipulation along with occasional stair climbing, squatting, and crawling. (PX 4, p. 13). Mr. Pagella testified that Petitioner's job was a heavy type of position. (PX 4, p. 19). Mr. Pagella reiterated that it would be difficulty finding alternative work, however, would recommend providing him with vocational rehabilitation services. (PX 4, p.23). He further noted that he began giving Petitioner job placement services on March 19, 2021. (PX 4, p. 24). Petitioner had several interviews but obtained no job offers yet. He further opined that vocational services were important because Petitioner was a younger individual. He noted his physical limitations were the most limiting factor for Petitioner returning to work. (PX 4, p. 29). He opined Petitioner would likely earn anywhere from $11-$16.00 an hour depending on if he found a job in Chicago or outside Chicago. (PX 4, p. 33). Mr. Pagella was adamant that Petitioner's restrictions were per the FCE and that Dr. Lubenow referenced those FCE restrictions in his last visit records of 12/10/20. (PX 4, p. 61). PX 2.

Respondent submitted a vocational profile report prepared by Daniel Minnich in June of 2021. (RX 4). Mr. Minnich reviewed medical records but did not meet with the Petitioner. Mr. Minnich opined that Dr. Lubenow released Petitioner to light duty. Regarding the National Tea analysis, he concluded that Petitioner could return to work without formal vocational rehabilitation. Mr. Minnich noted that the Petitioner had transferrable skills that allow him to return to work in the competitive labor market and in suitable gainful employment without further training. A Labor market was conducted identifying positions anywhere from $12.00/hour to $52,000/a year. (RX 4).

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be a credible witness. Petitioner testified consistently with the medical treatment contained in the medical records. He testified he began vocational rehabilitation with Mr. Pagella. He advised that he did not ask for his job back from Respondent because he thought there would be no work available for him with his restrictions. He has applied for Social Security Disability and is currently receiving the same. Petitioner wants to go back to work and wants to continue with job search assistance. He further testified that he has interviewed for a job but did not receive the same. He continues to look for work.

Currently he is still experiencing burning pain in both of his arms and legs, as well as stabbing pain in both of his arms, legs, and hands. He has trouble walking, as the more he walks the more pain he experiences. He was limited in his activities of daily living and no longer exercises. His average pain was around a four or to five out ten, which was better than before he had his spinal cord stimulator implanted. As such the spinal cord stimulator has helped his previous symptoms. He testified that he only sees Dr. Lubenow and has an upcoming appointment in December.

CONCLUSIONS OF LAW

The Arbitrator incorporates the foregoing findings of fact into the following conclusions of law.

Issue F, Whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. 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. Even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." International Harvester v. Industrial Com., 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982).

The Arbitrator finds that Petitioner established a causal relationship between the undisputed December 28, 2017 injury and his current condition of small fiber neuropathy as diagnosed by Dr. Lubenow. The Arbitrator notes that Petitioner's symptomology began worsening as early as March 15, 2018 when he felt a nerve type pain. Petitioner consistently complained of nerve like symptoms after this date.

The Arbitrator notes that Drs. Lubenow, Khan and Candido are all board certified and well-respected pain physicians. In evaluating their testimony, the Arbitrator places greater weight on Dr. Lubenow's testimony. Dr. Lubenow noted that small fiber neuropathy can be confused with CRPS. He further noted that skin punch biopsy showed that there was a presence of neuropathy. The Arbitrator notes that even Dr. Candido noted Petitioner may have small fiber neuropathy which was consistent with his original diagnosis of fibromyalgia. He noted, however, that work injury was not related to small fiber peripheral neuropathy. (RX 3). The Arbitrator agrees with Dr. Lubenow's reasoning as Petitioner had no complaints of pain in the right lower extremity prior to the accident. In addition, he noted that he has seen patients develop an aggravation of small fiber neuropathy after this type of injury.

The Arbitrator further acknowledges that Dr. Lubenow credibly opined that Petitioner's cerebral palsy or the fact that he was a smoker impacted his condition. Petitioner testified he was working full duty without limitation prior to his accident which Dr. Lubenow noted and weighed in his opinion. The Arbitrator further notes that Dr. Candido does not provide an explanation as to how Petitioner developed his current condition.

For the reasons discussed above and based on the greater weight of the evidence, the Arbitrator finds that Petitioner's condition of small fiber neuropathy is causally related to his work accident suffered on December 28, 2017.

As to issue "J", the reasonableness and necessity of medical care provided, the Arbitrator finds as follows:

Based on the record in its entirety, the Arbitrator finds Petitioner's treatment to be reasonable and necessary and finds that Respondent has not paid for said treatment. Given the Arbitrator's finding of causation between Petitioner's December 28, 2017 work accident and his condition of ill-being, Respondent is liable for reasonable and necessary medical treatment of the causally related condition.

As such, the Arbitrator orders Respondent to pay Petitioner the reasonable and necessary medical expenses incurred in connection with the care and treatment of his causally related condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

As to issue "K", regarding Petitioner's entitlement to Temporary Total Disability and Maintenance benefits, the Arbitrator finds as follows:

Petitioner was placed on work restrictions by Drs. Khan and Ho through March of 2019. Petitioner thereafter transferred care to Dr. Lubenow, per Dr. Ho, where he underwent a trial and permanent spinal cord stimulator process from July 2019 to November 2020. Petitioner underwent an FCE on November 9, 2020 and a final visit with Dr. Lubenow in December 2020. Given the consistent and continued medical treatment for the systemic disease of small fiber neuropathy and the need for a trial and then permanent spinal cord stimulator process, the Arbitrator finds that Petitioner is entitled to the requested period of temporary total disability of 110-3/7 weeks commencing 9/28/18 through 11/8/20. Respondent shall receive credit for amounts paid.

With regard to maintenance benefits, the Arbitrator notes Petitioner underwent a Functional Capacity Evaluation and was placed with permanent restrictions on November 9, 2020. Thereafter, Petitioner made a request for vocational services and met with Mr. Pagella on February 3, 2021. Petitioner then began a job search with evidence of sufficient job logs. (PX 22). As such, the Arbitrator finds that Petitioner is entitled to maintenance benefits commencing November 9, 2020 through the date of the trial date of August 11, 2021. Respondent shall receive credit for amounts paid.

As to issue "O", regarding Petitioner's entitlement to Vocational Rehabilitation Services: The Arbitrator finds as follows:

Given the Arbitrator's finding that Petitioner's condition of ill being is causally related to his December 28, 2017 work accident, Respondent is liable for vocational services pursuant to the Act. There is no question that Petitioner is not able to return to his pre-injury heavy-duty work level. The FCE clearly indicates Petitioner's restrictions as noted above. The Arbitrator reads Dr. Lubenow's record of 12/10/20 to clearly indicate that Dr. Lubenow read the FCE, incorporated those enumerated restrictions, and imposed an additional restriction of no lifting over 20 pounds. As such, the Arbitrator finds no valid dispute or inconsistency between the FCE restrictions and Dr. Lubenow's 20 pound restriction notation.

The Arbitrator finds the testimony of Mr. Pagella compelling over that of Mr. Minnich given the current posture of the case. Mr. Pagella recommended vocational services given Petitioner's age and physical limitations. Accordingly, the Arbitrator finds that Respondent is liable for past and continued vocational services pursuant to the Act. Given the above and based on the greater weight of the evidence, the Arbitrator awards Petitioner vocational rehabilitation services and finds Respondent shall pay for the costs of services rendered, and future costs of the continued vocational services pursuant to Section 8a of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC024991
Case Name	FIGUEROA, ERICA D v. TOOTSIE ROLL INDUSTRIES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0141
Number of Pages of Decision	31
Decision Issued By	Thomas Tyrrell, Commissioner, Thomas Tyrrell, Commissioner

Petitioner Attorney	Jennifer Kelly
Respondent Attorney	Julie Garrison

DATE FILED: 4/13/2022

/s/ Thomas Tyrrell, Commissioner

Signature

/s/ Thomas Tyrrell, Commissioner

Signature

22IWCC0141

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

Erica Figueroa,

Petitioner,

vs. NO: 18 WC 024991

Tootsie Roll Industries,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, prospective medical treatment, chain of referrals, and temporary total disability ("TTD"), and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Decision of the Arbitrator on the issues of medical expenses and prospective medical treatment, with the exception of chain of referrals pursuant to Section 8(a). The Commission affirms the Decision of the Arbitrator on the issue of causal connection, with the exception of duration of disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based on Dr. Balaram's opinions as stated in his report of June 5, 2019, the Commission finds Petitioner reached (maximum medical improvement) MMI as of June 5, 2019, and could return to work full duty without restrictions. Dr. Balaram evaluated Petitioner on May 28, 2019. He testified by way of evidence deposition that Petitioner's range of motion was consistent with a postoperative shoulder and could not identify anything on physical examination that would indicate she required specific work restrictions. Dr. Balaram issued a report on June 5, 2019, stating Petitioner reached MMI.

When Dr. Balaram re-evaluated Petitioner on January 21, 2020, he found her pain complaints to be out of proportion with her range of motion and strength testing. On physical examination, he noted slightly decreased range of motion and strength consistent with prior rotator

cuff repair. He reviewed the new MRI images from October 24, 2019, and found no pathology to warrant surgical intervention. As such, the Commission modifies the period of TTD to July 27, 2018 through June 5, 2019.

As it pertains to chain of referrals allowed pursuant to Section 8(a), the Commission finds that this issue was not waived by Respondent. At the Arbitration hearing on July 28, 2020, Respondent objected that Hinsdale Orthopaedics was outside the chain of referrals. (T. 63).

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 8, 2021, is modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary total disability benefits of $532.91/week from July 27, 2018 through June 5, 2019, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses associated with the care of Midwest Pain Specialists for the TENS unit only, Premier Health Services, and balance due the University of Illinois Hospital & Health System, subject to the fee schedule.

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 receive credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

April 13, 2022

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Decision of the Arbitrator. After carefully considering the totality of the evidence, I believe Petitioner met her

burden of proving her condition of ill-being remains related to the accident she sustained on July 21, 2018, and that said condition requires prospective medical care.

Petitioner sustained an undisputed accident on July 21, 2018, wherein she injured her right shoulder and neck. Respondent directed Petitioner to Concentra Medical Center and Excel Occupational Health Clinic. She presented to Midwest Anesthesia and Pain Specialists (hereinafter "MAPS") on July 27, 2018, where she was recommended for physical therapy, which she started the same date at ASRC.

MRI of the right shoulder on August 10, 2018 showed, (1) mild acromioclavicular joint osteoarthritis; (2) mild subacromial-subdeltoid bursitis; and (3) mild supraspinatus tendinopathy. MRI of the cervical spine on the same date showed, (1) patent central canal and neural foramina. No herniations noted; and (2) nonspecific straightening of the cervical lordosis, correlate for spasm versus strain.

After limited relief from right shoulder subacromial steroid injection, Petitioner was referred to Dr. Benjamin Goldberg at UIC, whom she began treatment with on September 14, 2018. Dr. Goldberg ultimately performed surgery to the right shoulder on November 20, 2018. Petitioner attended post-operative physical therapy at ASRC. On April 12, 2019, Dr. Goldberg recommended six weeks of work conditioning followed by a Functional Capacity Evaluation (FCE).

Petitioner was evaluated for work conditioning on April 19, 2019 at AthletiCo. She demonstrated capabilities and functional tolerances within the sedentary physical demand level with 7.5 pounds the heaviest weight she able to lift. An AthletiCo progress reported dated May 3, 2019 found her incapable of the physical abilities needed to return to her occupation as a laborer for Respondent. She was not lifting more than 10 pounds in work conditioning.

Petitioner followed-up with Dr. Goldberg on May 24, 2019, with continued complaints of burning pain. Her range of motion remained limited in abduction to about 90 degrees due to pain. Physical examination also showed weakness, with 4/5 strength on the right side. Dr. Goldberg recommended an additional month of physical therapy and an MRI, followed by an FCE pending the MRI results.

Respondent then sent Petitioner for a Section 12 Examination with Dr. Balaram on May 28, 2019. At this appointment, Petitioner complained of significant right upper extremity pain, including the right shoulder, upper arm, and occasional burning pain into the forearm. She reported frequent headaches and some right-sided neck pain as well. Petitioner was emotional during this examination, and Dr. Balaram found that she had symptom magnification. He opined her motion was consistent with a post-operative shoulder and indicated she could return to work without restriction. He did not have the benefit of reviewing the work conditioning reports that objectively showed she could not lift more than 10 pounds at this time.

Petitioner followed-up with Dr. Goldberg on June 23, 2019, at which time he observed limited active range of motion due to significant pain, as well as palpable swelling over the lateral aspect of the shoulder. Given this objective finding and her continued pain complaints, Dr.

Goldberg again requested an MRI of the right shoulder. He opined she was not at maximum medical improvement (MMI).

MRI of the right shoulder was obtained on July 23, 2019. The impression listed: (1) Extensive artifacts seen at the region of the acromioclavicular joint and along the superolateral humeral head due to prior surgery; (2) artifacts also seen within the humeral head due to prior surgical intervention; (3) small cyst/erosion measuring 0.4 cm seen at the superolateral head along attachment site of the supraspinatus tendon; (4) Mild tendinosis of the distal supraspinatus tendon seen, however no gross rupture noted; (5) Mild subacromial subdeltoid bursal effusion is seen; (6) Mild glenohumeral joint effusion is seen; and (6) No other significant abnormality noted.

Petitioner followed-up with Dr. Goldberg on August 3, 2019, with complaints of pain and clicking in the shoulder, as well as the inability to abduct the shoulder fully. Dr. Goldberg offered an injection, but Petitioner declined. Dr. Goldberg agreed Petitioner should obtain a second opinion and an FCE.

Thereafter, Petitioner sought a second opinion with Dr. Robert Thorsness at Hinsdale Orthopaedics on October 7, 2019. Physical examination showed decreased strength, positive Jobe test, positive lift off test, positive bear hug test, positive Hawkins impingement test, positive Neers impingement test, positive Speed's test for the biceps, positive O'Brien's test for SLAP, and positive cross body adduction test for AC joint. Cervical spine examination demonstrated restricted range of motion and paraspinal muscle tenderness. Dr. Thorness read the MRI to show subacromial bursitis, but noted that due to the very poor image quality of the MRI it was non-diagnostic. He recommended repeat MRI with high quality closed MRI.

MRI of the right shoulder was obtained on October 24, 2019, showing: (1) limited study due to susceptibility artifact related to post-surgical changes of rotator cuff repair and by the AC joint; (2) No full-thickness rotator cuff tear; (3) Mild increased signal by the supraspinatus myotendious junction, possibly from sprain; (4) Mild increased fluid in subacromial subdeltoid bursa; and (5) Post-surgical changes of biceps tenodesis.

On November 4, 2019, Dr. Thorsness read this MRI to show sequelae of previous rotator cuff repair and biceps tenodesis, severe acromioclavicular joint arthritis, spurring of the undersurface of the acromion with associated partial thickness bursal sided rotator cuff tearing consistent with extrinsic impingement, and subacromial bursitis. Dr. Thorsness administered a corticosteroid injection, as was previously recommended by Dr. Goldberg.

On December 16, 2019, Petitioner reported temporary relief from the injection. Dr. Thorsness recommended revision right shoulder arthroscopy with subacromial decompression, distal clavicle excision, and evaluation for possible rotator cuff repair. By February 3, 2020, Petitioner reported her injection had completely worn off. Dr. Thorness continued to recommend surgery at visits through July 20, 2020.

Dr. Thorsness testified by way of evidence deposition on June 22, 2020. Dr. Thorsness testified that Petitioner's MRI findings were consistent with her subjective complaints. He administered a subacromial cortisone injection for diagnostic and therapeutic purposes. He

testified he would not recommend revision surgery without some relief from injection to ascertain the most symptomatic area for the patient. Petitioner did report substantial temporary relief from the injection. Given this, and the objective findings with corroborative MRI, revision arthroscopy was recommended.

Dr. Thorsness noted that on his physical examination, Petitioner had notable Hawkins and Neer impingement findings, as well as other pertinent findings, which were consistent throughout Petitioner's course of care with him. While he agreed with Dr. Balaram that prior decompression should have addressed any impingement in her shoulder, he saw a small edge on the front of the acromion on the MRI that appeared to still be impinging, which was just above the area where there was a bursal-sided cuff tear. This area was also coated with inflammation on the MRI, which led him to conclude this was the area of pathology causing Petitioner's complaints. Therefore, he recommended revising the AC joint with distal clavicle excision.

Notably, and most convincingly, Dr. Thorsness agreed that Petitioner was an emotional person and may display some element of symptom magnification, but her symptoms correlated with MRI findings, his physical examination, and the substantial improvement from cortisone injection. He testified that most patients who fabricate their symptoms do not report substantial improvement from injection. Contrary to the Arbitrator's opinion, Dr. Thorsness supported his treatment plan with objective findings, without reliance on Petitioner's reporting.

Dr. Balaram testified by way of evidence deposition on June 30, 2020. On cross-examination, he agreed that the work conditioning progress report dated May 3, 2019 indicated Petitioner was not able to perform the physical capabilities of a laborer. He also agreed an FCE remains an appropriate option at this point.

Dr. Balaram conceded that if a patient experiences pain relief from such an injection, it can support a surgical recommendation. If she responded to an injection that took away all her pain, Dr. Balaram agreed that would evidence she needed a repeat surgery. Petitioner had such temporary but complete relief, thus Dr. Balaram's opinion that this surgery is not necessary to cure Petitioner of the effects of her injury is unpersuasive.

For the foregoing reasons, I would reverse the Decision of the Arbitrator in its entirety. The evidence establishes that Petitioner's ongoing right shoulder condition and related complaints are credible and corroborated by the medical records and expert testimony, and that her current right shoulder condition remains causally related to her work injury of July 21, 2018. The factual and medical evidence establishes Petitioner has not yet reached maximum medical improvement and requires further treatment as recommended by Dr. Thorsness. This treatment does not exceed her chain of referrals pursuant to Section 8(a).

o: 10/5/2021
TJT/ahs
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

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

22IWCC0141

FIGUEROA, ERICA D
Employee/Petitioner

Case# **18WC024991**

TOOTSIE ROLL INDUSTRIES
Employer/Respondent

On 1/8/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JENNIFER J C KELLY
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
JULIE GARRISON
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)

ERICA D. FIGUEROA, Case # **18 WC 24991**
Employee/Petitioner

v.
TOOTSIE ROLL INDUSTRIES,
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 **July 28, 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 during 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, **July 21, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,567.24**; the average weekly wage was **$799.37**.

On the date of accident, Petitioner was **34** 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 **$23,524.17** for TTD, $ **0** for TPD, $ **0** for maintenance, and **$4,796.10** for other benefits (permanency advance) for a total credit of **$28,320.27**.

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

ORDER

Petitioner failed to prove that she is entitled to the recommended prospective medical care and, therefore, Petitioner's claim for prospective medical is denied.

Respondent shall pay Petitioner temporary total disability benefits of $**532.91**/week for **46 & 4/7** weeks, commencing **7/27/2018** through **6/17/2019**, as provided in §8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from July 27, 2018 and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$23,524.17** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of Midwest Pain Specialists for the TENS unit only, Premier Health Services and balance due the University of Illinois Hospital & Health Sciences System as provided in §§8(a) and 8.2 of the Act.

Respondent shall be given a credit of $60,984.30 for medical benefits that have been paid.

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

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

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

Signature of Arbitrator

January 3, 2021
Date

ICArbDec19(b)

JAN - 8 2021

Erica D. Figueroa v. Tootsie Roll Industries
18 WC 24991

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?; ***L:*** What temporary benefits are in dispute? TTD

STATEMENT OF FACTS

Petitioner Erica Figueroa was 34 years old on the date of her accident, July 21, 2018. At that time, she was employed as a General Laborer by Respondent Tootsie Roll Industries. She had been working for Respondent since May 2016. Petitioner described job duties: packing candy bins from conveyors, which including grabbing and catching the candy bins weighing 50 pounds and then carrying and stacking the bins onto pallets. Petitioner testified that she would repeat these tasks throughout her entire shift.

Petitioner testified that she reported for work as usual on July 21, 2018 and was feeling great. On that day, she had to grab, pick up, and bring down bins to get them ready for the forklift driver to take the pallet away. She testified that as she was adjusting a bin, she felt something pop in her right shoulder. Her supervisor, Josefina Garcia, approached her to ask what happened and she informed Ms. Garcia it felt like something snap in her shoulder.

Ms. Garcia asked Petitioner if she needed to go to the hospital, but Petitioner declined. She told Ms. Garcia she thought she would be all right. Ms. Garcia said she would complete an incident report, but meanwhile she wanted Petitioner to finish dumping the bins onto the "bed." Petitioner stated that as she did this, her right hand and arm up to her neck started burning. She then told her supervisor she needed to go to the hospital.

Petitioner testified that she had never injured her right shoulder or received treatment for her right shoulder before her work accident. She is right-hand dominant. From the time she started working at Tootsie Roll in May 2016 through her accident on July 21, 2018, Petitioner stated she had been performing her full duty work activities as a laborer without a problem before her accident.

Petitioner testified that her supervisor directed her to go to Concentra, which she did on the date of accident (PX #1). At that visit, she reported she was bending over to pick up a bin and felt a pop and pain in her right shoulder. She further reported that after informing her supervisor, she was told to empty several more bins and the pain and popping sensation worsened. She was diagnosed with a rotator cuff strain and placed on restricted work. Petitioner returned to Concentra on July 23, 2018 and reported worsening right shoulder symptoms.

Following her injury, Petitioner resumed light duty work for a few days. On July 26, 2018, she presented to Excel Occupational Clinic for further evaluation at the direction of Respondent's in-house nurse, Nancy Trejo (PX #2). Petitioner again reported experiencing pain in her right shoulder when lifting a 50-pound bin of candy. She was diagnosed with a right biceps strain and trapezius strain and placed on restricted work. Petitioner was only seen at this facility once.

On the next day, July 27, Petitioner was evaluated by Billy Hayduk PA-C at Midwest Anesthesia & Pain Specialists ("MAPS") to initiate treatment (PX #3). She again reported a history of injuring her right shoulder while lifting and dumping a 50-pound bin at work. She also reported neck pain. On examination of the right shoulder she had diminished, painful range of motion. She had negative Neer's and empty-can signs but had a positive O'Brien's. The diagnoses were neck pain, cervical radiculopathy, and right shoulder pain. Physical therapy and medication were ordered. Petitioner was completely restricted from working for four weeks.

On that same day, July 27, 2018, Petitioner began therapy at the ASRC Clinic with chiropractor Dr. Ansu Durgut (PX #4). Given her persistent right shoulder symptoms over the following weeks, MRI studies of the right shoulder and cervical spine were ordered by Dr. Durgut. Both MRIs were performed on August 10, 2018 (PX #3 & PX #10). The cervical MRI demonstrated no disc herniation or bulging but straightening of cervical lordosis, consistent with a spasm or strain. The right shoulder MRI demonstrated mild acromioclavicular joint osteoarthritis, mild subacromial subdeltoid bursitis, and mild supraspinatus tendinopathy.

Petitioner returned to MAPS on August 15, 2018 and September 12, 2018,reporting some relief with a TENS unit but still ongoing burning pain in the right shoulder. The physical exams were essentially unchanged. Ongoing therapy and a right shoulder subacromial injection were recommended August 15. Petitioner also had continued to receive therapy at the ASRC Clinic, with a visit on September 12, 2018. Petitioner was referred to an orthopedic specialist, Dr. Benjamin Goldberg, for further evaluation.

On September 14, 2018, Petitioner consulted Dr. Goldberg at University of Illinois Hospital and Health Sciences System. She again reported a history of her injury and described 6-7/10 pain in the anterior aspect of her right shoulder. She also reported discomfort around the scapula and neck, and numbness and tingling in her thumb and long and small fingers. On physical examination, Petitioner was tender to palpation over the bicipital groove, the AC joint, and the scapula. She had positive Hawkins', O'Brien's, Speed's, and crossover signs. Dr. Goldberg reviewed the shoulder MRI, noting it was of very poor quality. Dr. Goldberg diagnosed rotator cuff and biceps tendinopathy and administered a corticosteroid injection to the right shoulder.

Petitioner testified that the injection gave her a few days of relief. She returned to Dr. Goldberg on September 28, 2018. She reported that the injection provided temporary relief, but her pain had since returned. She also reported numbness and tingling in the small and ring fingers. Dr. Goldberg recommended surgery. Pending surgery, Petitioner continued therapy at the ASRC Clinic through November 14, 2018, reporting constant, achy, and burning right upper extremity pain.

Petitioner returned to PA Hayduk at MAPS October 3, 2018. Her complaints and exam findings were essentially unchanged. An EMG/NCV to evaluate cervical radiculopathy as well as physical therapy and TENS were ordered.

Dr. Goldberg performed a right shoulder arthroscopy, mini-open rotator cuff repair with patch, subacromial decompression, biceps tenodesis and distal clavicle resection on November 20, 2018 (PX #10).

Petitioner followed up with Dr. Goldberg on November 26, 2018, December 14, 2018, January 25, 2019, and February 22, 2019. During that time, she resumed physical therapy at ASRC on December 5, 2018 and was limited to restricted work by Dr. Goldberg (PX #4 & PX #5). Petitioner testified that Dr. Goldberg was aware of the facility where she was obtaining post-operative therapy and he never told her to go to a different facility or expressed concerns about the ASRC Clinic. Petitioner also continued to receive care at MAPS through February 6, 2019. The ASRC records indicate that at three months post-operatively, on February 20, 2019, Petitioner reported ongoing right shoulder pain and difficulty with sleeping and activities of daily living. Petitioner's was last treated at ASRC on April 11, 2019.

At a follow up visit on April 12, 2019, Dr. Goldberg noted Petitioner had improved range of motion but needed to work on endurance and strengthening. Although petitioner had full range of motion of forward flexion, abduction, as well as full external and internal rotation, she still had pain in the proximal biceps region and was concerned

that something was abnormal. Dr. Goldberg recommended a course of work conditioning followed by an FCE. He limited Petitioner to a 5-pound lifting restriction.

Petitioner underwent a work conditioning evaluation at Athletico on April 19, 2019 and attended 9 sessions through May 3, 2019 (PX #6). On that last date, a work conditioning functional status report was completed and noted that Petitioner did not demonstrate the physical abilities needed to return to her job with Respondent. Specifically, this report stated Petitioner only met 31.25% of the reported job demands required to function as a general laborer and her capabilities were consistent with functioning at the Sedentary Physical Demand level. The therapist recommended that work conditioning be discontinued, and that Petitioner should return to her treating physician to determine the future care plan.

On May 24, 2019, Petitioner returned to Dr. Goldberg with continuing burning pain in the right shoulder. The physical examination revealed limited active abduction of the shoulder and weakness, but passive range of motion was full. Dr. Goldberg noted that Petitioner demonstrated the ability to tolerate up to only 7 pounds of lifting in therapy. Dr. Goldberg recommended additional therapy as well an updated MRI of the right shoulder.

At the request of Respondent, Petitioner underwent a §12 IME with orthopedic surgeon Dr. Ajay Balaram on May 28, 2019 (RX #4). Dr. Balaram noted in his June 5, 2019 report that Petitioner gave a history of her accident while lifting 50 pound bins. Dr. Balaram noted that he had Petitioner demonstrate the mechanism of her injury. Petitioner complained of stabbing pain with reduced range of motion in her right shoulder. Her pain limited her use and function. She also complained of occasional burning in the forearm. She reported some improvement with surgery but had ongoing right shoulder pain and decreased range of motion.

Dr. Balaram noted that Petitioner cried throughout the physical examination, even prior to any maneuvers. She cried during her description of her condition. She reported that she was not crying because of pain but mostly because of the "situation." Dr. Balaram noted that Petitioner was cooperative with the examination but exhibited symptom magnification, noting non-anatomic and non-physiologic findings. In addition to the clinical examination Dr. Balaram reviewed Petitioner's job description, medical records of treating physicians, right shoulder X-rays, and the September 26, 2018 IME report from Dr. Lewis, who found no objective evidence of orthopedic pathology and had recommended no further medical treatment.

Dr. Balaram conducted a physical examination of both upper extremities and the cervical spine. The examination of the cervical spine noted tenderness over the right paracervical muscles. The examination of the cervical spine was otherwise normal, as was the examination of the left upper extremity and the right elbow.

The examination of the right shoulder revealed a well-healed arthroscopic incision; there was no erythema, fluctuance, or drainage. Petitioner had forward elevation to 170°, external rotation to 70°, abduction to 85°, and internal rotation to the buttock. Dr. Balaram noted global right shoulder nonanatomic pain with light touch. Strength was 5/5 with external rotation and abduction. Internal rotation strength was 5- out of 5 in forward elevation with the arm slightly abducted. There was no atrophy of the infraspinatus, supraspinatus, or deltoid muscles

Dr. Balaram opined that Petitioner had sustained a work-related injury to her right shoulder on July 21, 2018 and agreed the surgery performed by Dr. Goldberg was appropriate and causally related. He further stated that postoperative chiropractic care was not appropriate. He noted that appropriate postoperative care should be provided by a licensed physical or occupational therapist. Dr. Balaram further stated that Petitioner had "failed" work conditioning and had extensive subjective complaints. Dr. Balaban did not see a need for pain management after a routine shoulder arthroscopy, particularly with the "polypharmacy" provided. He opined that Petitioner had reached MMI and could return to full duty work without restrictions now 6 ½ months postoperative. He based that opinion on Petitioner's objective strength, near full active range of motion, and no objective findings indicating residual disability. He further opined that further medical treatment was not likely to improve Petitioner's condition.

Petitioner returned to Dr. Goldberg on June 21, 2019. It was noted the updated MRI was still pending. Dr. Goldberg noted, "we do believe that there may be an abnormality given the swelling in the shoulder and her continued pain."

A repeat right shoulder MRI was performed on July 23, 2019 (PX #5 & PX #10). The radiologist noted postsurgical artifacts, a small cyst/erosion at the superolateral head, mild tendinosis of the distal supraspinatus tendon, mild subacromial subdeltoid bursal effusion, and mild glenohumeral joint effusion. The radiologist specifically noted that there was no full-thickness tear of the rotator cuff.

Petitioner returned to Dr. Goldberg on August 2, 2019, reporting right shoulder pain and clicking and an inability to abduct the shoulder fully. Dr. Goldberg reviewed the MRI and found it unremarkable except some tendinitis and a humeral cyst. On physical examination, Petitioner demonstrated limited active range of motion but had passive

range of motion. Dr. Goldberg suggested an injection, but Petitioner declined. The possibility of a second opinion was addressed, and Dr. Goldberg stated he was agreeable to Petitioner obtaining a second opinion. The plan was to proceed with the second opinion consultation and/or obtain a FCE.

Dr. Goldberg's August 2, 2019 clinical note contained a gap which was suggestive of Dr. Goldberg's suspicion that Petitioner's complaints were unrelated to the recent MRI findings.

Petitioner testified that she declined the injection offered by Dr. Goldberg because she was upset that there was nothing more he could do for her and she wanted to seek another opinion.

Dr. Balaram wrote a report August 19, 2019, in which he reviewed the July 23, 2019 MRI (RX #4). He noted the MRI demonstrated a healed rotator cuff and that all findings were consistent with post-surgical changes and his previous examination. Dr. Balaram did not change any of his prior opinions and did not believe any further medical treatment was indicated.

On October 7, 2019, Petitioner sought a second opinion with orthopedic surgeon Dr. Robert Thorsness of Hinsdale Orthopaedics (PX #7). She testified that she researched online to find a good doctor, had asked a couple people for suggestions, but was ultimately referred to Dr. Thorsness by her attorney.

Petitioner gave a history of an injury at work from heavy repetitive lifting. It was noted that Petitioner previously had right shoulder arthroscopic debridement, distal clavicle excision, subacromial decompression, and open rotator cuff repair and biceps tenodesis by Dr. Goldberg in November 2018. Petitioner reported that she had extensive physical therapy as well as work conditioning but still complained of significant pain, weakness, and dysfunction of her right upper extremity.

On examination, Dr. Thorsness noted tenderness of AC joint, greater tuberosity, and trapezial area, active elevation of 100°, passive elevation to 170°, and external rotation at 60°. He noted diminished strength. He also noted positive Jobe, lift-off, bear-hug, Hawkins', Neer's, cross-body adduction, Speed's, and O'Brien's signs. Belly-press, Hornblower's, Sulcus, and scapular winging were negative. There was no shoulder muscular atrophy, and Petitioner was neurovascularly intact. Dr. Thorsness also noted inappropriate mood and affect.

Dr. Thorsness found the July 2019 MRI to be very poor quality and recommended a closed MRI. However, he noted the MRI indicated subacromial bursitis. His diagnostic impression was persistent right shoulder pain following right shoulder surgery. He was also suspicious of cervical radiculopathy and recommended a right upper extremity EMG to rule out cervical radiculopathy versus subscapular nerve entrapment. He also noted Petitioner was unable to work.

The closed right shoulder MRI was performed October 24, 2019 (PX #7). The radiologist noted postsurgical changes and artifacts in the rotator cuff, AC joint, and biceps. There was no full thickness rotator cuff tear but there was a non-detached labral tear. There was also mild increased signal by the supraspinatus myotendinous junction possibly from sprain, mild increased fluid in subacromial subdeltoid bursa, and post-surgical changes of biceps tenodesis.

The November 4, 2019 EMG was noted as normal (PX #7).

Petitioner returned to Dr. Thorsness' office and was seen by Marie Kirincic and PA Christopher Bridgeman on November 4, 2019. It was noted that the EMG was normal. The closed MRI was personally reviewed, and noted the sequelae of previous rotator cuff repair and biceps tenodesis, severe acromioclavicular joint arthritis, spurring of the undersurface of the acromion with associated partial thickness bursal sided rotator cuff tearing consistent with extrinsic impingement, subacromial bursitis, and no evidence of full thickness rotator cuff tear.

Dr. Thorness's impression was impingement syndrome, right partial thickness bursal sided rotator cuff tear, subacromial bursitis, and severe AC joint arthropathy. PA Bridgeman administered a diagnostic and therapeutic right subacromial cortisone injection to the right shoulder. However, he noted it was unlikely the injection would provide definitive pain relief and a revision surgery would likely be necessary. Mr. Bridgeman noted Petitioner could work with a lifting restriction of one to five pounds, and no overhead work with the right upper extremity.

In follow up on December 16, 2019, Petitioner reported temporary benefit from the injection but noted ongoing shoulder pain especially with increased use (PX #7). Dr. Thorsness recommended surgery to obtain more definitive pain relief, and he noted they would await approval from workers' compensation. Specifically, he recommended a revision right shoulder arthroscopy with subacromial decompression, distal clavicle excision and evaluation for possible rotator cuff repair.

Petitioner was re-examined by Dr. Balaram on January 21, 2020 pursuant to §12 of the Act (RX #4). In addition to a clinical examination Dr. Balaram reviewed records

from Dr. Thorsness, the October 24, 2019 MRI, and the November 4, 2019 EMG. In his February 4, 2020 report Dr. Balaram noted Petitioner reported right-sided neck pain, right shoulder and upper arm pain, difficulty lifting her arm, and difficulty sleeping. She had switched treating physicians for a second opinion. Her current physician was recommending another surgery. Petitioner reported the recent injection provided a little relief. She also reported that she was told recent MRIs showed a tear in the shoulder.

On examination, Petitioner there was mild tenderness over the right and left paracervical muscles. Spurling's was negative bilaterally. Examination of the left upper extremity was essentially normal. Examination of the right upper extremity revealed well-heeled arthroscopic incisions and an interior biceps tenodesis incision. Range of motion of the right shoulder know what noted normal forward elevation but external and internal rotation were diminished, as well as abduction. Petitioner reported pain at the ends of ranges of motion. She had a mildly positive Hawkins sign but had negative drop-arm, empty-can, O'Brien's, Neer's, Yergason's, apprehension relocation, and belly press and lift off. Examination of the right biceps was essentially normal.

Dr. Balaram noted that Petitioner was cooperative throughout the examination but again noted symptom magnification. She again demonstrated non-anatomic and non-physiologic pain distribution. He noted Petitioner's report that she could not lift her arm but that she demonstrated an ability to lift her arm in full forward elevation to 180°. She also complained of pain with squeezing of the hand and making a fist. Although she reported difficulty with abduction, her abduction was nearly symmetric with the contralateral side.

Dr. Balaram reviewed the October 24, 2019 MRI which showed the post-surgical changes at the distal clavicle, expected because of the prior distal clavicle excision. He also noted the previous decompression had addressed any impingement findings because there was a Type I flat acromion without inferior downsloping. The labrum and subscapularis were intact. Rotator cuff and biceps tendon anchors were well-seated. There was no evidence of retraction or re-tear. Dr. Balaram's interpretations were consistent with those of the radiologist.

Dr. Balaram did not agree with the need for additional surgery. Dr. Balaram reiterated his finding that Petitioner's right shoulder condition and original surgery with Dr. Goldberg were causally related to her work injury of July 21, 2018, but opined that it was doubtful additional surgery would alleviate Petitioner's symptoms. Dr. Balaram based his opinion on Petitioner's symptom magnification, as well as exam findings that did not follow anatomic or physiologic distributions. He noted that her treating physician had found near full range of motion but with pain after repetitive action. Dr. Balaram

noted this was inconsistent with mechanical derangement or continued impingement or re-rupture of the rotator cuff after subacromial decompression and rotator cuff repair. He further commented that this agreed with Petitioner's original treating surgeon. Dr. Balaram opined that Petitioner had reached MMI and could return to unrestricted use of her right shoulder.

Petitioner acknowledged she was evaluated twice by Dr. Balaram, May 28, 2019 and January 21, 2020. She testified that she told him her complaints and cooperated with his evaluations. However, she testified that Dr. Balaram never examined her upper extremities or her cervical spine. She testified he did not evaluate her right shoulder, right elbow, or left upper extremity. She said he did not conduct range of motion testing or any provocative testing. She stated he did not examine me at all and only asked her where it hurt. She further testified that he spent "like five minutes" with her.

Petitioner has continued with Dr. Thorsness, with additional visits on February 3, March 16, April 2, June 8, and July 20, 2020. The records reflect Petitioner reported progressing right shoulder symptoms with significant pain and dysfunction which limited her ability to perform activities of daily living. Dr. Thorsness continued to reiterate his recommendation for a revision surgery. Petitioner testified that Dr. Thorsness has repeatedly physically examined her during her appointments and has continued to recommend surgery for her right shoulder.

Dr. Robert J. Thorsness gave his evidence deposition June 22, 2020 (PX #9). Dr. Thorsness is a board-certified orthopedic surgeon. He has no subspecialty certification for shoulders. He refreshed his memory from his office notes of Petitioner's care.

Dr. Thorsness testified he first saw Petitioner on October 7, 2019. She gave a history of injuring her right shoulder as she was lifting a heavy box at work. Dr. Thorsness understood that she initially received nonsurgical treatment from Dr. Goldberg, but that Dr. Goldberg ultimately performed a right shoulder arthroscopy, a debridement, a distal clavicle excision, subacromial decompression, as well as an open rotator cuff repair and biceps tenodesis in November 2018. She had postoperative physical therapy. Dr. Thorsness testified that he had reviewed Dr. Goldberg's records.

Petitioner presented with complaints of continuing significant pain and weakness, as well as dysfunction with any activity at shoulder height or above. Dr. Thorsness testified that on exam Petitioner was tender over the AC joint and over the greater tuberosity, as well as the trapezial area. She had some limitation in active range of motion up to 100° without pain but had passive range of motion that was normal. Petitioner had rotator cuff weakness, with positive Jobe's, lift-off, passive bear-hug tests, consistent with subscapularis pathology. Petitioner also have positive Hawkins and Neer impingement

signs which were consistent with extrinsic subacromial impingement in addition to positive Speed's and O'Brien's tests. Dr. Thorsness also found a positive cross-body adduction test, which is pathognomonic for symptomatic AC joint.

Dr. Thorsness noted the July 23, 2019 right shoulder MRI was of very poor quality. Typically, he would not order an open MRI when considering surgery. Therefore, he recommended a high-quality closed MRI and an EMG. He was concerned that Petitioner had a failed rotator cuff repair or subscapularis nerve entrapment neuropathy. In addition, he kept Petitioner off work.

Dr. Thorson is reviewed the October 24, 2019 MRI images. He saw sequela of a previous rotator cuff repair as well as a biceps tenodesis, both of which appeared fine. He noted residual severe AC joint inflammation and arthritis. There was anterior spurring of the undersurface of the acromion and a partial thickness bursal-sided rotator cuff tear that was consistent with extrinsic impingement. There was also severe subacromial bursitis but noted there was no evidence of a re-tear at the repair site.

Dr. Thorsness took special note of the "tremendous" amount of AC joint and subacromial bursa inflammation. He observed a small area of spurring on the undersurface of the acromion. Noting that his interpretation of the MRI differed from the radiologist's, he commented that oftentimes radiologists are looking for different things and that he, as a treating surgeon well note subtle findings on thorough evaluation.

Dr. Thorsness noted that Petitioner had a healed rotator cuff repair and a healed biceps tendon tenodesis, but that she still be appeared to have residual extrinsic subacromial impingement with subacromial bursitis, and residual symptomatic AC joint arthritis. He recommended a diagnostic and therapeutic subacromial cortisone injection, which was administered November 4, 2019. On that date, Dr. Thorsness returned Petitioner to light duty work with no lifting greater than 5 pounds and no overhead use of the right arm.

When Petitioner returned on December 16, 2019 she reported temporary relief from the injection but that her pain had returned. Dr. Thorsness then recommended revision arthroscopy involving subacromial decompression, revision distal clavicle excision, and reevaluation of the rotator cuff. He recommended revision surgery because of Petitioner's extensive postoperative care that had not provided relief.

Dr. Thorsness also opined that Petitioner's MRI findings were consistent with her findings on examination as well as her subjective complaints, which supported the recommendation for surgery.

Dr. Thorsness further testified that Petitioner's current right shoulder condition is causally related to her work injury of July 21, 2018, and noted the fact that Petitioner had no pain prior to her work injury and then had pain after her injury is consistent with there being a causal relationship. Dr. Thorsness also opined that the surgery performed by Dr. Goldberg, as well as the surgery he recommends, were both reasonable, necessary, and causally related to the work injury. He further stated Petitioner's injections and therapy were reasonable and medically necessary as well.

Dr. Thorsness noted his findings on physical examination were different from Dr. Balaram's findings. He found Petitioner had notable Hawkins and Neer impingement signs and other findings that were present at multiple appointments and remained consistent throughout her course of care. As for indications for surgery, Dr. Thorsness explained there remains a small edge on the front edge of the acromion per the MRI that is still impinging and that should be decompressed. He also opined that the dorsal side of the AC joint had not been resected with the prior surgery and should be resected. Moreover, Dr. Thorsness stated that while Petitioner is a very emotional person, he believes her symptoms correlate with the MRI findings and the physical examination findings and support the need for surgery.

On cross-examination, Dr. Thorsness agreed that on August 2, 2019, Dr. Goldberg found Petitioner's complaints were unrelated to the July 23, 2019 MRI results. He conceded that the interpreting radiologist of the October 24, 2019 MRI did not find spurring of the undersurface of the acromion associated with rotator cuff tearing, or impingement. Dr. Thorsness also stated he ordered an EMG, but denied he also suspected possible cervical radiculopathy. He testified the EMG was more to rule out suprascapular nerve or notch findings. He stated the EMG test was reported normal in the office notes, but a separate report was not included in his records. He agreed his positive provocative test results were indicative of subjective pain complaints. He acknowledged there was no change in his findings on March 16, 2020 or June 8, 2020 re-examinations.

Dr. Thorsness also testified that he had not reviewed records of Advanced Spine and Rehab Center or of Dr. Durgut. He did not know Dr. Durgut. He did not know that she was a chiropractor. He was not aware that Dr. Durgut had referred Petitioner to him and he did not recall any prior referral from Dr. Durgut. He did not speak to Dr. Durgut regarding Petitioner.

Dr. Thorsness further testified that he prescribed Tramadol on an ongoing basis as a common practice and part of his routine practice, as well as in Petitioner's case. He testified the expected post-operative course would include physical therapy and that he refers his patients to licensed physical therapists. He did not find it appropriate for a

chiropractor to conduct post-shoulder surgery physical therapy. Dr. Thorsness testified he had not reviewed a job description, any job activity video, or visited the plant. He indicated he relied on Petitioner's description of having a highly repetitive job.

Dr. Ajay Balaram's evidence deposition was taken on June 30, 2020 (RX #3). Dr. Balaram is a board-certified orthopedic surgeon specializing in upper extremities, including shoulders. He refreshed his memory with the reports of his two IMEs and one record review. He had reviewed Petitioner's medical records, including those of Dr. Goldberg and Dr. Thorsness, as well as MRIs.

Dr. Balaram testified to Petitioner's report of her work injury and her medical care including shoulder surgery. Dr. Balaram noted that Petitioner underwent subacromial decompression where access to the subacromial space was gained and the subacromial decompression performed. The distal end of the clavicle which was then resected. He confirmed his opinion that there was a causal relationship between Petitioner's reported work accident of swinging a 50 pound box and the pathology in her right shoulder found during surgery. He noted that Petitioner's surgery and related medical care by Dr. Goldberg was reasonable and necessary.

Regarding Petitioner's exam on May 28, 2019, Dr. Balaram testified Petitioner was 6 1/2 months status post-right shoulder rotator cuff repair with distal clavicle excision, biceps tenodesis, and subacromial decompression with a good prognosis from an objective standpoint. He noted his findings of good strength associated with the rotator cuff, active range of motion near normal, and objective healed rotator cuff repair without complications associated with surgery.

Regarding the provocative shoulder testing, Dr. Balaram explained they look for specific anatomic locations with residual complaints. He stated a mildly positive Hawkins sign can be consistent with rotator cuff tendinopathy, but he also found a negative Neer's sign, which is negative for impingement. Dr. Balaram testified these results were a disconnect in Petitioner's examination.

Dr. Balaram also testified Petitioner's pain complaints were out of proportion given her range of motion and associated strength. Also, her subjective pain complaints were not within a distribution that followed anatomic or physiologic distribution. He did not find any pain reported over the AC joint or associated with the acromion. He also found Petitioner's reporting pain when making a fist was inconsistent with any type of shoulder pathology.

Dr. Balaram testified he did not see much change between his examinations and that both examinations were indicative of a healed rotator cuff repair. He examined Petitioner's right bicep, forearm, wrist, and fingers, as well as cervical spine. Left and right cervical paracervical muscles were tender to palpation. Dr. Balaram also testified regarding his examination of the left shoulder, elbow, and wrist, finding them all within normal limits.

Dr. Balaram reviewed of the October 24, 2019 MRI report and images along with notes from Dr. Thorsness. Dr. Balaram testified the labrum, subscapularis rotator cuff tendon, biceps tendon, and rotator cuff were all intact. He saw no evidence of retraction or re-tear of the rotator cuff. He also noted the distal clavicle excision had been performed. Dr. Balaram testified that he did not note any spurring of the undersurface of the acromion on the October 24, 2019 MRI. He did not note any associated partial thickness tearing.

Regarding the Type I flat acromion without any downsloping finding, Dr. Balaram testified if he had seen something other than a normal acromion or a Type 1 flat acromion, he would have noted it. He explained a Type 1 acromion would indicate no spurring on the undersurface of the acromion. A Type 1 acromion also indicates that the impingement on the rotator cuff had been appropriately resected by Dr. Goldberg in surgery November 20, 2018. Dr. Balaram also found no objective evidence of a small edge on the front of the acromion that had not been decompressed during the prior surgery. Nor did he note any severe or significant inflammation in the subacromial space or the AC joint. He did not see anything abnormal as far as the subacromial space or distal clavicle, noting that neither would appear normal given the previously operation. He testified that the distal clavicle changes were expected as the end of the clavicle had been taken out and would not appear normal.

Dr. Balaram had no findings of ongoing impingement, adding that strength and provocative testing did not support any evidence of continued impingement. Petitioner's symptoms did not specifically point to impingement. Dr. Balaram also testified that the MRI finding of increased signal where the muscle attaches to the tendon was from the patch for the rotator cuff repair. Similarly, Dr. Balaram stated abnormal finding at the myotendinous junction was the patch repair at that level and was not evidence of tearing associated with the rotator cuff. Dr. Balaram also testified resecting the entire end of the collarbone and the undersurface of the acromion left space to be filled and fluid there was a post-surgical change.

Dr. Balaram opined that further surgical intervention was not warranted because the changes on MRI were consistent with post-surgical changes and Petitioner's pain

complaints were inconsistent with any anatomy amenable to surgical intervention. He explained there was nothing to address surgically and alleviate Petitioner's pain. He testified that Petitioner's pain complaints did not concur with any objective findings or imaging that would potentially make her better. His recommendation was to avoid further surgery.

Dr. Balaram testified that given the lack of objective findings associated with the shoulder, he found Petitioner able to return to work without restrictions. He added that Petitioner's subjective complaints did not follow an anatomical or physiological distribution or correlated with a medical need for specific restrictions. Dr. Balaram reiterated that he found no evidence of continued impingement or re-rupture of the rotator cuff, citing his strength and range of motion testing.

On cross-examination, Dr. Balaram testified that work conditioning and a functional capacity evaluation might be appropriate depending on a patient's response and subjective willingness to perform. He noted Petitioner was able to abduct her shoulder fully at the time of Dr. Goldberg's August 2, 2019 final office visit. He agreed that surgeons should personally review MRI images and it is his practice to personally review them, adding surgeons correlate those findings with examination.

Dr. Balaram further testified the patch repair associated with post-surgical changes could be interpreted as effusion. He testified that commonly used provocative shoulder tests by orthopedic specialists can be very sensitive for certain pathologies, but they are not necessarily specific and multiple different tests may be inconsistent with a specific anatomic injury.

Dr. Balaram also agreed that persistent shoulder pain with persistent impingement can be indications for surgical intervention, and that a positive response to an injection can be supportive of a decision for surgery. He acknowledged that Dr. Thorsness is repeatedly documented positive impingement signs, such as Hawkins. He further acknowledged that treating physicians have knowledge in addition to an MRI to support a decision for surgery. Treating physicians are in the best position to make decisions regarding a patient's case, but that may not necessarily be the correct decision. He added that reasonable physicians may disagree regarding the necessity of surgery.

On redirect examination, Dr. Balaram testified that Petitioner told him the November 2019 diagnostic injection might have helped a little bit. (R x 3, pp. 57 and 58). He stated by her own history, the injection performed by Dr. Thorsness did not provide full relief, adding she was also being assessed for neck pathology. Dr. Balaram testified there was no clear indication the injection provided sufficient relief to warrant surgical

intervention. In Petitioner's case, he did not see her response to the injection as evidence surgery would alleviate her pain. He stated that Petitioner did not complete relief from the injection so as to support repeat surgery, especially given the surgery she had already been through.

Dr. Balaram confirmed he conducted an independent review of the MRI images and, further, interpretation of the MRI must be correlated with physical examination findings including the previous surgery changes. He testified that the radiologist's abnormal findings are explained by Petitioner' prior surgery that changed the anatomy of the shoulder. The MRI findings, the physical exam findings, and Petitioner's symptoms did not line up, specifically noting Petitioner's complaints of pain out of proportion with the MRI and physical exam. Without such correlation or specific evidence of orthopedic pathology to be addressed surgically, he did not recommend surgical intervention.

CONCLUSIONS OF LAW

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

It is undisputed that Petitioner sustained a compensable work-related accidental injury on July 21, 2018. Petitioner was diagnosed with right shoulder biceps tendinitis, rotator cuff tear, and AC joint arthropathy. Petitioner received conservative medical care but ultimately underwent arthroscopic subacromial decompression, biceps tenodesis, distal clavicle excision, and rotator cuff repair with patch.

What is disputed is whether Petitioner's current condition of ill-being of claimed continued pain and limitation are causally related to the original injury on July 21, 2018 and whether Petitioner is entitled to prospective medical care to relieve those complaints. In that regard, the Arbitrator finds that Petitioner failed to prove that her current condition of ill-being of continued pain and limitation are causally related to the original injury on July 21, 2018.

Orthopedic surgeon Dr. Benjamin Goldberg of University of Illinois Hospital and Health Sciences System performed arthroscopic and mini open surgery on Petitioner's right shoulder on November 20, 2018, after failed conservative care. The reasonableness and necessity of Dr. Goldberg's care and the prior conservative care are not disputed. Dr. Goldberg's supervised postoperative care was also reasonable and necessary, but for the chiropractic care discussed below.

Petitioner followed through 2019 with continuing right shoulder complaints of weakness and limited motion. Dr. Goldberg ordered additional therapy and an updated

right shoulder MRI, which Dr. Goldberg found to be unremarkable. Throughout the 2019 follow-ups with Dr. Goldberg Petitioner demonstrated improvement, including full passive range of motion despite continued active range of motion limited by pain. Dr. Goldberg's final note on August 2, 2019 suggested he believed Petitioner's subjective complaints were inconsistent with her objective presentation and the MRI. Dr. Goldberg then agreed with Petitioner's desire for a second opinion but did recommend an FCE. Dr. Goldberg did not at that time suggest or recommend a revision surgery of Petitioner's right shoulder.

Prior to leaving Dr. Goldberg's care Petitioner was examined May 28, 2019 pursuant to §12 of the Act by orthopedic surgeon Dr. Ajay Balaram. Dr. Balaram noted that Petitioner had normal strength and near normal range of motion in her right shoulder. He noted non-anatomic subjective complaints of pain. He noted that were no objective findings indicating residual disability Based on his clinical examination and review of Petitioner's medical records Dr. Balaram opined that Petitioner was at MMI and could return to full duty work. He further opined that further medical care was not likely to improve Petitioner's condition.

Petitioner was dissatisfied with lack of resolution of her continuing complaints and sought a second opinion for her condition. On referral by her attorney, Petitioner consulted Dr. Robert Thorsness October 7, 2019. Dr. Thorsness conducted a clinical examination and reviewed Petitioner's July 2019 MRI, which he noted was of poor quality. Dr. Thorsness recommended a closed MRI of the right shoulder and an EMG. Dr. Thorsness diagnosed shoulder impingement syndrome, right partial thickness bursal-sided rotator cuff tear, subacromial bursitis, and severe AC joint arthropathy. He then recommended revision surgery for Petitioner's right shoulder.

Petitioner was examined again by Dr. Balaram on January 21, 2020, when he also reviewed Petitioner's updated medical including the October 2019 MRI and the EMG. He again found symptom magnification with no objective basis for Petitioner's subjective complaints. Dr. Balaram found near normal range of motion in Petitioner's right shoulder, as did Dr. Thorsness. Dr. Balaram noted the October 2019 MRI showed postsurgical changes, as did the interpreting radiologist. He reiterated his opinion that petitioner had reached MMI and could return to unrestricted use of her right shoulder. He also repeated his opinion that revision surgery would not relieve Petitioner's problems.

In reviewing all the evidence, particularly Petitioner's testimony and the opinions of Petitioner's treating physicians, as well as the opinions of Respondent's §12 examining physician, the Arbitrator finds that Petitioner failed to prove that her current claimed

condition of ill-being in her right shoulder is causally connected to her work-related accidental injury on July 21, 2018.

The conflicting medical opinions are based on differing interpretations of clinical exam findings, MRI imaging, and, in large part, the reliability of Petitioner's subjective complaints. Dr. Thorsness derived more aggressive diagnoses and treatment recommendations than did Dr. Balaram. Dr. Thorsness now recommends revision surgery while Dr. Balaram, who did not find an objective basis for Petitioner's complaints, opined that surgery was not warranted.

The Arbitrator does not find Dr. Thorsness's opinions, either diagnoses or surgical recommendation, persuasive. Dr. Thorsness's reading of MRI imaging differed from the radiologist and Dr. Balaram. The number of witnesses testifying to a particular fact or issue may not be convincing if a lesser number of witnesses is more convincing when testifying to that factor issue. Here, however, the Arbitrator finds the opinions of the greater number more persuasive than the lesser number.

The Arbitrator is also noted that both Dr. Goldberg and Dr. Balaram found Petitioner's subjective complaints were inconsistent with objective clinical findings. In particular, Dr. Balaram found at both of his IMEs that Petitioner's complaints were non-anatomic and non-dermatomal.

In addition, both Dr. Thorsness and Dr. Balaram observe that Petitioner was highly emotional during various examinations. While this does suggest that Petitioner was untruthful in her reports about her complaints and condition such emotionality does detract from the accuracy of her reporting. The Arbitrator finds that Dr. Thorsness's opinion lack reliability because of his misplaced reliance on the accuracy of Petitioner's reporting.

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?

Respondent paid a total of $60,984.30 in medical expenses. Petitioner now seeks payment of several medical bills and balances (PX #8).

Advanced Spine and Rehab Clinic (ASRC):

After her initial July 27, 2018 evaluation and before the November 20, 2018 surgery, Dr. Durgut of ASRC provided chiropractic care and therapy through November 14, 2018. Respondent paid ASRC for intermittent dates of service from July 27, 2018

through September 26, 2018; November 6, 2018 to December 18, 2018; and February 1, 2019 to February 4, 2019 (PX #8 & RX #1).

Petitioner testified after Dr. Goldberg operated on her shoulder, she went back to Dr. Durgut for therapy. She testified that Dr. Goldberg was aware of her post-operative care from Dr. Durgut. Petitioner continued to see Durgut through April 11, 2019. Yet, the reports of Dr. Durgut do not reference Petitioner's post-surgery condition beyond a single reference at the first visit of December 5, 2019 and are virtually identical from session to session with no indication of progress or improvement. Eventually, Dr. Goldberg sent her to Athletico for work hardening/conditioning where she was seen by licensed therapists.

Dr. Durgut is a chiropractor and not a licensed physical therapist. Both Dr. Thorsness and Dr. Balaram agreed during their deposition testimony that post-shoulder surgery therapy should be conducted by a licensed physical therapist and not a chiropractor.

The Arbitrator finds the post-surgery treatment at ASRC by Dr. Durgut was not reasonable or necessary to cure or relieve the effects of Petitioner's work-related conditions. The services of Dr. Durgut are awarded only through November 14, 2018. Respondent is entitled to credit for payments exceeding the amount due pursuant to the fee schedule as of November 14, 2018. The bill for ASRC dates of service beginning December 5, 2018 and thereafter are denied.

Midwest Pain Specialists (durable medical equipment)

This bill is for neuromuscular stimulator (TENS) unit, Game Ready cold compression therapy unit rental, and a Continuous Passive Motion machine rental. Respondent has not paid any of the amounts billed. The TENS unit was provided on August 15, 2018 at PA Hayduk's recommendation (PX #3 & PX #4). The Arbitrator finds the item to be reasonable and awards costs related to the TENS unit, adjusted in accord with medical fee schedule.

Dr. Goldberg recommended a 30-day rental of the Game Ready Unit and requested this item again (to include wrap, setup, and delivery) for an 8-week post-surgery period. Dr. Goldberg also recommended a Shoulder CPM for the post-surgery period (PX #4 & PX #5).

Respondent submitted these requests for Utilization Review. In a February 8, 2019 report, Rising Medical Solutions determined the Game Ready Unit was not necessary for shoulder use per the Official Disability Guidelines (RX #2). There was no indication to utilize the Game Ready unit outside the recommendations of the guidelines. Therefore, this item was not authorized.

Regarding the shoulder CPM rental, Rising Medical Solutions' February 8, 2019 UR report stated it was not recommended according to the Official Disability Guidelines for shoulder rotator cuff conditions, but was an option for established adhesive capsulitis for a period up to 4 weeks (RX #2). As the guidelines do not support the use of this device outside of adhesive capsulitis, it was not supported for rotator cuff pathology. Therefore, this request was not certified and became final as to the shoulder CPM.

Non-certification of the Game Ready device was appealed. Rising Medical Solutions' appeal determination was reported on July 11, 2019. The prior non-certification was upheld, specifically finding no indication supporting the use of the Game Ready device in the shoulder was recommended, either prior to surgery or afterwards.

Based on the non-certifications and denials pursuant to Utilization Review and citations to the Official Disability Guidelines, the Arbitrator finds the charges of Midwest Pain Specialists for the Game Ready and shoulder CPM units were not proven reasonable and necessary to cure or relieve the effects of the work injury. The associated charges are therefore denied.

§8(a) Choice

Also, Respondent argues that Petitioner exceeded the number of choices of treating physicians permitted by §8(a) of the Act. This disputed issue was not raised in the Request for Hearing, Arbitrator's Exhibit #1. Further, this issue was not raised by Respondent when, prior to presentation of evidence, the parties were asked if there were any other disputed issues than causation, reasonableness of medical bills, TTD, and prospective medical care. Both parties replied that there were no other disputed issues, pages 6 and 7 of the Transcript. Therefore, the Arbitrator finds that Respondent waived any claimed violation of §8(a) choice.

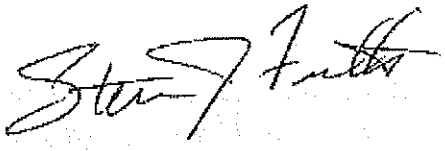
K: Is Petitioner entitled to prospective medical care?

Inasmuch as the Arbitrator has previously found that Petitioner failed to prove that her claimed current condition of ill-being is causally related to her accidental work injury suffered on July 21, 2018, it follows that Petitioner failed to prove that she was entitled to the prospective medical care claimed to be necessary to cure or relieve the effects of the claim current condition of ill being.

Even so, the Arbitrator notes that Dr. Goldberg reviewed Petitioner's post-operative complaints without recommending a revision of the right shoulder surgery.

L: What temporary benefits are in dispute? TTD

Based on the evidence including the opinion of Dr. Balaram noting that Petitioner had reached MMI, the Arbitrator finds Petitioner proved she was temporarily totally disabled from July 27, 2018 to July 17, 2019, 46 & 4/7 weeks. Based on Dr. Balaram's persuasive opinion regarding Petitioner's MMI the Arbitrator finds Petitioner was able to resume unrestricted work and daily activities and was no longer temporarily totally disabled.



Steven J. Fruth, Arbitrator

January 3, 2021
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	10WC036000
Case Name	ROA, JORGE v. MARIO C MARCIEL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0142
Number of Pages of Decision	4
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Chris Cooper
Respondent Attorney	

DATE FILED: 4/15/2022

/s/Carolyn Doherty, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JORGE ROA,

Petitioner,

vs. NO: 10 WC 36000

MARIO C. MARCIEL,

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner timely filed a Petition for Review of the Arbitrator's order denying reinstatement of his case. On review, Petitioner requests the Commission grant reinstatement of his case. The Commission, after considering the record in its entirety, and being advised of the facts and law, denies Petitioner's motion to reinstate. The Commission's findings of fact and conclusions of law are as follows.

I. STATEMENT OF FACTS

Procedural History and Record of Proceedings on the Motion to Reinstate

On September 20, 2010, Petitioner filed an Application for Adjustment of Claim alleging he sustained injuries while at work on September 13, 2010. The Application was filed by the law firm of Goldstein, Aiossa & Good. On January 21, 2011, James Ellis Gumbiner & Associates filed a Substitution of Attorneys for Petitioner. On July 18, 2017, a Motion to Withdraw filed by Respondent's attorney was granted and for the remainder of the case, Respondent was not represented by Counsel.

On October 30, 2017, Arbitrator Granada, while sitting in the Wheaton venue, dismissed this case for want of prosecution. Seventy-nine days later on January 16, 2018, Petitioner's counsel "discovered" that this matter had been dismissed for want of prosecution. On January 19, 2018, Petitioner filed a Motion to Reinstate and set it for the February 8, 2018 status call before Arbitrator Steffen, who was then sitting in Wheaton. That motion was not set and had to be refiled; thus, Arbitrator Steffen did not hear the Motion to Reinstate until May 1, 2018. On May 1, 2018, the Arbitrator advised Petitioner's Counsel that she could not reinstate the case

because she was not the original Arbitrator who dismissed the case. Petitioner's Counsel then filed a second Motion to Reinstate before Arbitrator Granada in Bloomington. That motion was not set for hearing and thereafter, Petitioner's Counsel filed a third motion to reinstate on June 29, 2018. The motion was ultimately heard by Arbitrator Granada in Bloomington on August 28, 2018.

During the hearing before Arbitrator Granada, Petitioner's Counsel asserted that the motion to reinstate was timely filed on January 19, 2018, three days after he discovered the dismissal while checking IWCC records on January 16, 2018. Petitioner further asserts that despite the Substitution of Attorneys filed on January 21, 2011, the Commission's website never reflected his firm as attorney of record. Petitioner's counsel relies on this fact to assert that his firm never received notice that the case was dismissed on October 30, 2017. Again, Petitioner asserts that he only discovered the dismissal while checking the IWCC website on January 16, 2018, in preparation for a status update he planned to provide his client.

On August 28, 2018, Arbitrator Granada denied the Motion to Reinstate on the sole basis that he no longer had jurisdiction as the motion had been filed beyond the 60-day provision. In denying the motion to reinstate on jurisdictional grounds, the Arbitrator explained on the record that Commission Rule, Section 9020.90, specifically states the parties have 60 days from the receipt of the dismissal order to file a petition. The Arbitrator concluded he did not have jurisdiction and noted it would be left to the Commission to determine the merits of the case and petition to reinstate. On September 27, 2018, Petitioner filed a timely Petition for Review.

II. CONCLUSIONS OF LAW

Petitioner's Petition for Review filed on September 27, 2018, requests the Commission review the Arbitrator's denial of reinstatement and grant reinstatement of this matter. Commission Rule 9020.90 instructs that "where a cause has been dismissed from the arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a petition for reinstatement of the cause onto the arbitration call*"* and *"*[p]etitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned." *See* 50 Ill. Adm. Code 9020.90(a) – (e).

In support of his request to reinstate, Petitioner's Counsel asserts that IWCC system never listed his firm as the attorneys of record following the filing of the substitution and thus, he never received a Notice of Dismissal from the IWCC. The Commission addressed this same argument in *Hardaway v. Provena Senior Services* wherein it denied reinstatement explaining that it is the responsibility of the Petitioner's attorney "to check that they were listed as attorney of record or check the status sheets or check the Commission data base" and failure to do so was a failure to diligently monitor and pursue the case. *Priscilla Hardaway v. Provena Senior Services*, 2012 Ill. Wrk. Comp. LEXIS 1548, 12 IWCC 1454 (2012). As in the *Hardaway* case, the Commission here finds no evidence that Petitioner's Counsel made any efforts to rectify the error in the IWCC system at any time after the Substitution was filed on January 21, 2011, and before the dismissal of the case almost seven years later. Furthermore, the Application for Adjustment of Claim was filed in September 2010, and as such the case was on file with the IWCC for three or

more years as of September 2013. It can be reasonably inferred from the procedural history, that despite not being listed as attorney of record in the IWCC system, Petitioner's Counsel was able to track the case while it was "above the red line" and properly request continuances to avoid dismissal for at least four years before the dismissal in October of 2017. Relying on the well-founded reasoning in *Hardaway*, the Commission rejects Petitioner's argument that the Motion to Reinstate was timely filed following his "discovery" of the dismissal on January 16, 2018. In the case at bar, as did the Commission in *Hardaway*, we conclude this is not a docketing or clerical error that resulted in Petitioner's failure to receive notice of the dismissal. Rather, it was a clear failure to check on the status of the case until January 16, 2018. The Commission denies reinstatement in this matter concluding that Petitioner's Counsel failed to diligently monitor and pursue the case resulting in the late filing of Petitioner's Motion to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Motion to Reinstate is denied.

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

April 15, 2022

o: 04/07/22
CMD/JJM
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019265
Case Name	WILLIAMS, JOHNELL v. AMSTED RAIL COMPANY, INC.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0143
Number of Pages of Decision	10
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Mary Massa, Matthew Chapman
Respondent Attorney	Julie Pagano

DATE FILED: 4/15/2022

/s/Stephen Mathis, Commissioner

Signature

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

Johnell Williams,

Petitioner,

vs. NO: 18WC 19265

Amsted Rail Company, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2021, is hereby affirmed and adopted.

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

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

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

April 15, 2022

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-3/16/22
44

/s/ *Deborah J. Baker*
Deborah J. Baker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019265
Case Name	WILLIAMS, JOHNELL v. AMSTED RAIL COMPANY, INC.
Consolidated Cases	No Consolidated Cases
Proceeding Type	Request for Hearing – Nature and Extent Only
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	William Gallagher, Arbitrator

Petitioner Attorney	Matthew Chapman
Respondent Attorney	Julie Pagano

DATE FILED: 11/5/2021

/s/William Gallagher, Arbitrator

Signature

INTEREST RATE WEEK OF NOVEMBER 2, 2021 0.06%

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Johnell Williams
Employee/Petitioner

v.

Amsted Rail Company, Inc.
Employer/Respondent

Case # 18 WC 19265

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on September 28, 2021. By stipulation, the parties agree:

On the date of accident, June 11, 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 $79,088.88; the average weekly wage was $1,520.94.

At the time of injury, Petitioner was 53 years of age, single, with 0 dependent child(ren).

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

Respondent shall be given a credit of $21,583.02 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $21,583.02. The parties stipulated TTD benefits were paid in full.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $790.64 per week for 25.625 weeks because the injury sustained caused the 12 1/2% loss of use of the right hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

November 5, 2021

ICArbDecN&E p. 2

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 June 11, 2018. According to the Application, Petitioner "injured hands shoveling" and sustained an injury to his "right hand, left hand" (Arbitrator's Exhibit 2). Petitioner and Respondent stipulated medical and temporary total disability benefits had been paid in full and the only disputed issue was the nature and extent of disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a laborer. On June 11, 2018, Petitioner was shoveling sand and the handle of the shovel jammed into the palm of his right hand. Petitioner felt a "pop" in his right hand and had swelling as well as a diminished range of motion of the right hand. Petitioner testified he went to an ER of a local hospital, but the records of that visit were not tendered into evidence.

Petitioner was subsequently evaluated and treated by Dr. David Brown, an orthopedic surgeon. Dr. Brown initially saw Petitioner on June 18, 2018. At that time, Petitioner complained of pain/swelling in the right hand and difficulties closing the fingers of the right hand. Petitioner also lacked grip strength of the right hand. Dr. Brown ordered an MRI scan of Petitioner's right hand (Petitioner's Exhibit 1).

The MRI was performed on June 27, 2018. According to the radiologist, the MRI revealed tenosynovitis involving the third digit from the palm through the mid-proximal phalangeal level (Petitioner's Exhibit 2).

Dr. Brown saw Petitioner on June 27, 2018, and reviewed the MRI. His interpretation of the MRI was consistent with that of the radiologist. Dr. Brown administered an injection into the flexor tendon sheath of the middle finger (Petitioner's Exhibit 1).

Dr. Brown saw Petitioner on July 11, 2018. At that time, Petitioner complained of pain/stiffness in the mid palm of the right hand. Dr. Brown diagnosed Petitioner with tenosynovitis of the right hand. He administered another injection into the flexor tendon sheath of the middle finger (Petitioner's Exhibit 1).

Dr. Brown saw Petitioner on September 12, 2018, and Petitioner advised the injection helped, but he still had stiffness and difficulty making a fist. On examination, Dr. Brown noted Petitioner had tenderness over the A1 pulley of the right middle finger. He administered another injection into the tendon sheath of the middle finger (Petitioner's Exhibit 1).

When Dr. Brown saw Petitioner on October 29, 2018, Petitioner had recurrent pain in the palm of his right hand and triggering/locking of the right middle finger. Dr. Brown recommended Petitioner undergo surgery consisting of an A1 pulley release and possible tenosynovectomy (Petitioner's Exhibit 1).

Dr. Brown performed surgery on December 27, 2018. The procedure consisted of an A1 pulley release of the right middle finger (Petitioner's Exhibit 3).

Dr. Brown saw Petitioner on January 16, 2019, removed the sutures and instructed Petitioner to do home exercises. When he saw Petitioner on February 11, 2019, he noted Petitioner was doing well, had a good range of motion of the middle finger and no triggering (Petitioner's Exhibit 1).

Dr. Brown subsequently saw Petitioner on April 1, 2019. At that time, Petitioner complained of locking of the right ring finger. Examination revealed tenderness over the A1 pulley of the right ring finger. Dr. Brown diagnosed Petitioner with early tenosynovitis of the right ring finger and administered an injection into the tendon sheath (Petitioner's Exhibit 1).

When Dr. Brown saw Petitioner on April 29, 2019, Petitioner still had locking/triggering of the right ring finger. Dr. Brown recommended Petitioner undergo surgery (Petitioner's Exhibit 1).

Dr. Brown performed surgery on May 23, 2019. The procedure consisted of an A1 pulley release of the right ring finger (Petitioner's Exhibit 4).

Following surgery, Petitioner continued to be treated by Dr. Brown. When Dr. Brown saw Petitioner on July 8, 2019, Petitioner complained of increased swelling/pain. Dr. Brown recommended Petitioner be in a supervised therapy program and continue home exercises. He also prescribed an impact glove for Petitioner to wear as needed (Petitioner's Exhibit 1).

Dr. Brown saw Petitioner on August 14, 2019, and September 23, 2019. Petitioner's condition improved and Dr. Brown released him from care and authorized Petitioner to continue to work without restrictions (Petitioner's Exhibit 1).

Petitioner continued to have symptoms and sought treatment from Dr. Bruce Schlafly, a hand surgeon, who initially saw Petitioner on December 27, 2019. At that time, Petitioner complained of an inability to extend and flex the right ring finger. On examination, Dr. Schlafly noted a restricted range of motion of the right ring finger as well as diminished grip strength of the right hand when compared to the left. Dr. Schlafly opined Petitioner had a persistent right ring trigger finger and a secondary flexion contracture at the PIP joint. Dr. Schlafly recommended Petitioner undergo further surgery (Petitioner's Exhibit 6).

Dr. Schlafly performed surgery on February 27, 2020. The procedure consisted of a release of the right ring trigger finger with tenotomy of the flexor tendon (Petitioner's Exhibit 5).

Following surgery, Petitioner continued to be treated by Dr. Schlafly. When he saw Petitioner on March 11, 2020, and March 25, 2020, he noted Petitioner's range of motion had improved, but he gave Petitioner and extension splint to wear on the right ring finger at night (Petitioner's Exhibit 6).

When Dr. Schlafly saw Petitioner on April 22, 2020, Petitioner was still wearing the splint at night. Petitioner could make a fist and Dr. Schlafly authorized Petitioner to return to work at full duty effective April 27, 2020 (Petitioner's Exhibit 6).

Dr. Schlafly saw Petitioner on July 22, 2020, and Petitioner was still able to make a fist; however, Petitioner developed a flexion contracture at the PIP joint. Dr. Schlafly fitted Petitioner with a joint jack splint to correct the flexion contracture (Petitioner's Exhibit 6).

Dr. Schlafly again saw Petitioner on August 24, 2020. At that time, the joint flexion contracture had been corrected, but Dr. Schlafly recommended Petitioner use the joint jack splint on a part-time basis to prevent a reoccurrence of the flexion contracture (Petitioner's Exhibit 6).

Dr. Schlafly last saw Petitioner on December 2, 2020. Petitioner had continued to use the joint jack splint to the point to where it was worn out. Dr. Schlafly provided him with a new one. On examination, grip strength of the right hand was measured at 65 pounds and of the left hand at 80 pounds. At that time, Dr. Schlafly released Petitioner from care (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Shawn Kutnick, an orthopedic surgeon, on March 10, 2021. In connection with his examination of Petitioner, Dr. Kutnick reviewed medical records provided to him by Respondent. According to his report, Petitioner denied any pain in the hand or any specific limitations. Petitioner advised he experienced some soreness at night when sleeping, but this was not significant. On examination, Dr. Kutnick noted there was a 10° resting PIP flexion contracture of the right ring finger, but remainder of the examination was normal. Dr. Kutnick opined there were no major limitations/issues or significant pain in either hand, Petitioner was at MMI and no further treatment was indicated (Respondent's Exhibit 1).

At the time of trial, Petitioner was 57 years old and he agreed he was able to return to work to his regular job for Respondent. However, because of some layoffs, Petitioner was not working at his regular job at the time of trial, but anticipated he would be back to his regular position sometime in October. Petitioner is right hand dominant and he testified the grip strength of his right hand is less than what it previously was and he now uses his left hand more. He takes over the counter medication on a regular basis.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 12 1/2% loss of use of the right hand.

In support of this conclusion the Arbitrator notes following:

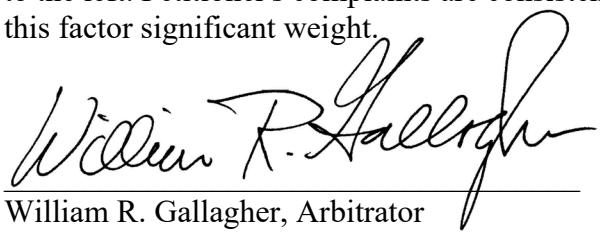
Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked for Respondent as a laborer. Petitioner was able to return to work to that position. Petitioner's job does require the active use of both of his hands. The Arbitrator gives this factor moderate weight.

Petitioner was 53 years old at the time he sustained the accident and 57 years old at the time of trial. Petitioner will have to live with the effects of the injury for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

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

Petitioner underwent three surgeries on his right hand, two for the condition of his right ring finger and one for the condition of his right middle finger. This has affected Petitioner's hand and Petitioner continues to have diminished grip strength of his dominant right hand when compared to the left. Petitioner's complaints are consistent with the injury he sustained. The Arbitrator gives this factor significant weight.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC042896
Case Name	MCCOY, DERRICK v. INTERSTATE BRANDS
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	22IWCC0144
Number of Pages of Decision	6
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Jay Janssen
Respondent Attorney	Marcy Bennett

DATE FILED: 4/15/2022

/s/Stephen Mathis, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DERRICK McCOY,

Petitioner,

vs. NO: 09 WC 42896

INTERSTATE BRANDS,

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTIONS 19(h) AND 8(a)

Timely Petition for Review under sections 19(h) and 8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of further permanent disability and further medical benefits, and being advised of the facts and law, denies the 19(h) and 8(a) petitions for the reasons set forth below.

Petitioner sustained a work-related accident on August 24, 2007. Mr. McCoy fell from a ladder and sustained injuries to his left shoulder, cervical spine, and bilateral hands and knees. Petitioner subsequently underwent a course of treatment that included surgery on his left shoulder, cervical spine, and left knee. He also received physical therapy and pain management services.

On August 20, 2015, the Arbitrator filed a decision finding that Respondent had paid all reasonable and necessary medical expenses pursuant to sections 8(a) and 8.2 of the Act. Petitioner was awarded permanent partial disability benefits corresponding to loss of 30% of the person as a whole for the cervical condition, 12.5% of the person as a whole for the left shoulder condition, and 17.5% loss of use of the left leg. The Arbitrator commented that he was making no award of permanency concerning Petitioner's right knee complaints. No prospective medical care was awarded. Neither party appealed the Arbitrator's decision.

On February 20, 2018, Petitioner timely filed a petition under sections 19(h) and 8(a) asking the Commission to make a "finding of increased disability (increased award), payment of medical bills by insurance company (Ace Property & Casualty Companies/ESIS) since June 16, 2015, under section 8(a), and demand for penalties pursuant to sections 19(k), 19(l) & section 16 of the Workers' Compensation Act, including attorney's fees and costs". In his brief Petitioner asks the Commission to:

> "award an increased disability to Derrick McCoy since the original arbitration decision to 90% of a man as a whole and require and order the Respondent's insurance company to pay all outstanding medical and require and to reimburse Medicare all bills paid by Medicare relative to injuries sustained by Derrick McCoy due to his industrial injury and further assess penalties against ACE Property & Casualty Companies/ESIS for Interstate Brands for willful violation of the Court Order of August 20, 2015 for the non-payment of medical bills, denial of medical treatment to Derrick McCoy, all reasonably necessary secondary to the workers' compensation injury of August 24, 2007. Attorney's fees and costs shall be assessed pursuant to Section 16. The Workers' Compensation Commission should grant such further relief as becomes necessary during the pendency of this motion."

Respondent did not file a response brief on the pending petitions. Dr. Lawrence Li, a board- certified orthopedic surgeon performed a Section 12 evaluation of Petitioner at the request of Respondent on October 4, 2021, and prepared a report (RX2), which was received into evidence at hearing. Dr. Li's report included an extensive review of records as well as his findings on physical examination. He concluded that neither Mr. McCoy's current condition of ill-being nor his need for prospective medical care is causally connected to the work accident in 2007. Petitioner did not testify in support of this petition at the hearing conducted on November 12, 2021, before Commissioner Mathis.

The assertion is made in Petitioner's brief that "the medical bills of Derrick McCoy since the original date of the arbitration, June 16, 2015, have been paid by Medicare, even though Petitioner has repeatedly requested the insurance company for Interstates Brands to reimburse Medicare. There has been no reimbursement to the best of the knowledge of Petitioner herein."

The assertion is unsupported by either the testimony or affidavit of Petitioner. No evidence has been presented of any communication from Petitioner to the insurance company. There is no record that these requests were made or even that the medical bills (PX8) were submitted to Respondent. Respondent entered into evidence a payment ledger (RX3) that reflects payment of certain medical bills spanning the period from May 11, 2016, through July 26, 2018.

Petitioner filed for disability benefits with the Social Security Administration. Following a trial Mr. McCoy was awarded permanent total disability on March 31, 2017, which entitled him to Medicare benefits. Petitioner asserts that Medicare has paid medical bills incurred by him

since the arbitration hearing date of June 16, 2015. These bills (PX8) were received into evidence at hearing. Several of the medical bills submitted by Petitioner in PX8 were bills with a date of service in 2014 which were previously paid by Respondent and encompassed in Arbitrator Dollison's prior Decision. Petitioner seeks to have Respondent's insurance carrier reimburse Medicare for the ongoing medical care he relates to his work accident

Among the records and bills submitted by Petitioner is a right shoulder MRI performed on January 16, 2018, related to a fall he sustained in mid -November 2017. He was diagnosed with a complete tear of the right rotator cuff and subsequently had surgery performed by Dr. Garst. Additionally, Petitioner has received treatment for bilateral carpal tunnel syndrome, bilateral knee pain, cervical pain, foot numbness, numbness of the bilateral upper extremities and ongoing complaints of pain and paresthesia throughout his body.

In 2019 and 2020 Petitioner returned to Dr. Stroink, a neurosurgeon for complaints of paresthesia and numbness of his right hand. Dr. Stroink had previously performed surgery on Mr.McCoy in 2011.A cervical MRI was performed on Dr. Stroink's order. No pathology was identified to explain Mr. McCoy's complaints. Dr. Stroink did not indicate in her clinical notes the opinion that his complaints were related to his prior cervical injury or subsequent surgical repair. Dr. Stroink discharged him from care with the recommendation that Petitioner consult Dr. Feather, a pain specialist to explore the option of a spinal cord stimulator to remedy his complaints of chronic pain.

On March 17, 2021, Petitioner, returned to Graham Medical Group, his pain management provider. requesting a referral for additional physical therapy. The documentation reflects that the option of a spinal cord stimulator was "re-discussed", and that Mr. McCoy stated that he did not want a SCS.

The medical records dating back as early as 2016 show that Petitioner sought treatment over the intervening years for a variety of complaints at Illinois Regional Pain Institute and Graham Health Systems. He was treated with pain medications that included Percocet, Oxycodone, and Tramadol. Respondent's payment ledger reflects payments made to Illinois Regional Pain Clinic as well as payment of pharmacy bills. Pharmacy records from Walgreen's (PX8), reflect payment for pain medications by both insurance and Medicare. It cannot be discerned whether any of these pharmacy bills had been submitted to Respondent's insurance carrier and denied, or only submitted for payment through Medicare. In any event based upon the evidence causal connection to the work accident has not been proven by Petitioner.

Petitioner has presented no evidence that Medicare has filed a lien in this matter. There was no evidence presented that there were medical claims or bills submitted to Respondent by Petitioner seeking reimbursement to Medicare. Based upon the paucity of evidence the Commission finds that Petitioner's request for reimbursement is premature and denies it on that basis as well as the failure to demonstrate that all of the medical disbursements made by Medicare were causally connected to the work injury.

Mr. McCoy was referred to Dr. Kinzinger, an orthopedic surgeon who examined him on August 23, 2021, for left knee osteoarthritis and complaints of pain going back 7.5 years. The history of left knee pain as expressed by Mr. McCoy himself and recorded in the clinical note would therefore date back to an onset in 2014, even prior the award of permanency on the left leg rendered in August 2015. Arbitrator Dollison awarded 17.5 % percent loss of use of the left leg.

The history of the case shows that Petitioner underwent a left knee arthroscopy in February 2010 and that Arbitrator Dollison found the need for the left knee arthroplasty to have been causally related to Mr. McCoy's work injury. Dr. Kinzinger documented a "long discussion" with McCoy concerning recommendations for weight loss, low impact exercise, and only non-steroidal pain medications or Tylenol for management of osteoarthritis preoperatively. Petitioner declined non-operative management and he was scheduled for a left total knee replacement. Petitioner seeks an award of prospective medical care for this surgery.

The Commission notes that Dr. Kinzinger's charting does not state that Mr. McCoy's need for a left total knee replacement is causally connected to either the August 2007 work injury or the 2010 left knee arthroplasty.

The Commission, having reviewed the medical records submitted by Petitioner finds that there is no evidence presented supporting a finding pursuant to section 19(h) that there has been a material increase in Petitioner's disability since the arbitration hearing in 2015. The Commission recognizes that Petitioner has received ongoing medical services since the arbitration hearing.

Petitioner did not submit reports from any of his treating physicians to establish an increase in his level of disability, causal connection between his current condition of disability to the work accident of August 24, 2007, or relating any of the bills for medical treatment incurred since June 16, 2015 to the accident.

For the foregoing reasons Petitioner's petition pursuant to 19(h) and 8(a) is hereby denied as is the petition for penalties/attorney's fees and reimbursement of Medicare. Furthermore, the Commission denies prospective medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under Section 19(h) of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition under Section 8(a) of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition to reimburse Medicare for medical disbursements is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties/attorney's fees under sections 19(k), 19(l) and section 16 of the Act is denied.

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.

April 15, 2022

s/*Stephen J. Mathis*
Stephen J. Mathis

SM/msb
d: 3/16/22
44

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

/s/ *Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC013587
Case Name	DUZAKOWITES, PAMELA v. BUD'S AMBULANCE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0145
Number of Pages of Decision	11
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Kurt Lloyd
Respondent Attorney	ROBERT SMITH

DATE FILED: 4/18/2022

/s/ Deborah Baker, Commissioner

Signature

22IWCC0145

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA DUZAKOWITES,

Petitioner,

vs. NO: 16 WC 13587

BUD'S AMBULANCE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b)[1] of the Act having been filed by the Respondent herein, and notice given to all parties, the Commission, after considering the issues of whether Petitioner's alleged accident arose out of her employment with Respondent, whether Petitioner's current condition of ill-being is causally related to the alleged accident, Petitioner's entitlement to prospective medical care and Petitioner's entitlement to temporary total disability benefits, and being advised of the facts and law, corrects the Decision of the Arbitrator as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E. 2d 1322 (1980).

The Commission hereby incorporates by reference the findings of fact and conclusions of law contained in the Decision of the Arbitrator, which delineate the relevant facts and analyses. However, as it pertains to temporary total disability, the Commission corrects the Decision of the Arbitrator. The Commission agrees with the Arbitrator that Petitioner is entitled to temporary total disability benefits from October 9, 2019 through the arbitration date of January 15, 2020. However, the Commission calculates that this time period equates to 14 & 1/7ths weeks, as opposed to the

[1] Based on the Transcript of Proceedings on Arbitration, the parties represented that they were trying the case pursuant to Section 19(b) of the Act.

14 weeks awarded in the Decision of the Arbitrator. The Commission corrects the "Order" section of the Decision of the Arbitrator to reflect this time period, and also corrects the corresponding amount owed, which should equal $8,320.97 as opposed to the $8,238.58 awarded in the Decision of the Arbitrator.

All else is affirmed.

IT IS THEREFORE FOUND BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2020, as corrected above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $588.47 per week for a period of 14 & 1/7ths weeks, representing $8,320.97 from October 9, 2019 through January 15, 2020, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the right total knee replacement, pre-diagnostic testing and supplemental surgical care as described in the medical records pursuant to the Medical Fee Schedule, as provided in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

April 18, 2022

O: 2/23/22
DJB/wde
043

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0145

DUZAKOWITES, PAMELA Case# **16WC013587**

Employee/Petitioner

BUD'S AMBULANCE

Employer/Respondent

On 3/13/2020, 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 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:

1702 GRAZIAN & VOLPE PC
TIMOTHY F WINSLOW
5722 W 63RD ST
CHICAGO, IL 60638

5001 GAIDO & FINTZEN
MONICA J KIEHL
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pamela Duzakowitcs,
Employee/Petitioner

v.

Bud's Ambulance
Employer/Respondent

Case # **16** WC **13587**

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 **Christopher Harris**, Arbitrator of the Commission, in the city of **CHICAGO**, on **January 15th, 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 Prospective Medical – Surgery Approval_____

FINDINGS

On **1/22/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **45,898.32**; the average weekly wage was $**882.66**.

On the date of accident, Petitioner was **43** years of age, single with **4** dependent children.

Petitioner has not received 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 since the Respondent refused to accommodate Petitioner's light duty restrictions, that the Petitioner was medically unable to work from 10/9/19 through 1/15/20, or 14 weeks. Petitioner's TTD rate is $588.47, therefore the amount of TTD owed by Respondent to Petitioner amounts to $8,238.58.

Respondent shall authorize and pay for the right total knee replacement, pre-diagnostic testing and supplemental surgical care as described in the medical records pursuant to the Medical Fee Schedule, as such treatment is reasonable, necessary and causally related to the subject accident as provided in Section 8(a) of the Act.

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

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

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

3/13/2020
Date

MAR 13 2020

FINDINGS OF FACT

Petitioner, Pamela Duzakowitcs ("Petitioner") was a 40-year old single woman with four children who worked for Respondent Bud's Ambulance on January 22, 2016. (Trial Transcript dated Jan. 15, 2020 ("Trans.") p. 8; Pet. Ex. 1-1)[1]. Petitioner testified she had been with the company since June of 2001 and was a supervisor at the time of the alleged injury. (Id. at 8, 9). On January 22, 2016, Petitioner went on her first call of the day to back up another crew for a patient who was unresponsive after being hit by a 2,000-pound metal slab in a very large trucking yard. (Id. at 9, 12). Her ambulance was parked about three loading docks away from where the patient was located. (Id.). Petitioner started CPR on the patient and continued CPR until extra help arrived, at which time they would jointly attempt to move the patient out from under the metal slab. (Id.).

Petitioner testified she had to run back and forth from the patient to the ambulance multiple times to get additional supplies. (Id. at 10). On her third trip, Petitioner was going to move the ambulance closer to the patient since the trucking yard dock had just been cleared of other trucks. (Id.). When Petitioner came around the front of the ambulance to enter on the driver's side, she started to slip on a patch of ice. (Id.). As she was falling, Petitioner grabbed onto the side view mirror of the ambulance, but her right knee twisted. (Id.) Petitioner did not fall to the ground. (Id.) Petitioner was able to enter the cab of the ambulance, drove it closer to the patient, and remined inside of the vehicle while the patient's coworkers loaded him into the ambulance. (Id.) Petitioner then drove the ambulance to the hospital. (Id.) After arriving at the hospital and transferring the patient to the hospital staff, Petitioner immediately called her supervisor, Ron Robertson ("Robertson"), and informed him that she had injured her right knee while working. (Id.) Another supervisor for the Respondent came to the hospital and took Petitioner back to the Respondent's command post. (Id.). While at her post, her other supervisor obtained injury reports from the Petitioner, her partner and the supervisor who gave Petitioner a drug test. (Id. at 11-12). Petitioner continued working her shift doing light duty at the post before being taken to an urgent care clinic - Physicians Immediate Care ("PIC"). (Id.; Pet. Ex. 3).

At PIC, Petitioner was diagnosed with a sprain of the right knee and provided PROVIL, ULTRAM, ibuprofen, and tramadol. (Pet. Ex. 3:5). The physician's treatment plan was for Petitioner to apply cold packs, keep the leg elevated, wear a hinged knee brace, and to follow the work restrictions of only sit-down work through January 25, 2016. (Id. at 3:2-5). Petitioner had a follow-up visit to PIC on January 25th where the treating physician referred Petitioner to see an orthopedic surgeon regarding knee strain and a possible meniscal tear. (Id. at 3:19). The treating physician again recommended Petitioner wear a hinged knee brace and continued the work restrictions through February 4, 2016. (Id.).

On January 30, 2016, Petitioner sought medical treatment at Midwest Orthopaedic Consultants from Dr. Luis Redondo ("Dr. Redondo"). (Trans. 13; Pet. Ex. 4). After examination, Dr. Redondo diagnosed Petitioner with effusion of the right knee, meniscus derangements, and unilateral post-traumatic osteoarthritis of the right knee. (Pet. Ex. 4:9). The treatment plan consisted of aspiration of the right knee joint, an MRI scan of the right knee and prescription Norco as needed. (Id.). The right knee aspiration and a right knee injection were completed the same day as the initial consultation. (Id. at 4:11-14). Dr. Redondo provided a work status form allowing Petitioner to return to work on desk duty until after an MRI was performed. (Id. at 4:48).

On February 4, 2016, an MRI of the right knee was completed with impressions of small knee joint effusion, grade IV chondromalacia at the medial femoral condyle, grade IV chondromalacia at the femoral trochlea and lateral patellar facet and had metallic susceptibility artifacts in the upper end of the tibia. (Id. at 4:24).

On February 10, 2016, Petitioner had her second follow-up visit with Dr. Redondo. (Id. at 4:5) The MRI was reviewed and the diagnosis was updated to reflect a contusion of the right knee, sprain of parts of the right knee and chondromalacia patellae of the right knee. (Id.). Dr. Redondo prescribed physical therapy, authorized Petitioner to return to light work duty and recommended reevaluation in six to eight weeks. (Id. at 4:5, 47). On

[1] Petitioner's exhibits were bates stamped utilizing exhibit number, a hyphen and a page number. (e.g. 1 -1 – denoting page 1 of Exhibit 1). To minimize confusion when citing multiple pages, Arbitrator has converted the hyphen to a colon for all applicable citations in this decision. (e.g. 1:1).

March 30, 2016, Petitioner had her third follow up visit with Dr. Redondo. Petitioner's diagnosis was modified to reflect unilateral-post-traumatic osteoarthritis in the right knee. (Id.). The treatment plan at this time was updated to order a venous Doppler ultrasound to rule out deep vein thrombosis ("DVT"), continued physical therapy, and Orthovisc injections. (Id. at 4:3). At Petitioner's fourth follow-up on May 25th, the treatment plan from the March 30th visit remained the same, but the Orthovisc injections and physical therapy were postponed until approved by the insurance company. (Pet. Ex. 5:3-4). Dr. Redondo provided an updated work status form clearing Petitioner to return to work on modified light duty. (Id. at 5:46).

Petitioner's fifth follow-up on July 20, 2016 remained similar to the findings of the visit on May 25th, but with the inclusion of a cortisone injection being performed on Petitioner's right knee. (Id. at 5:6-9). Dr. Redondo provided another work status form permitting Petitioner to return to work modified light duty. (Id. at 5:47). On August 24, 2016, Petitioner had a sixth follow up visit with Dr. Redondo. (Id. at 5:10). In updating his findings from previous reports, Dr. Redondo noted that Petitioner was awaiting insurance approval for the Orthovisc injections and was to begin physical therapy on August 29th. (Id.). He further noted that there was continued pain and swelling in the right knee. (Id.). Petitioner remained on modified, light work duty. (Id. at 5:48).

On October 17, 2016, an independent medical examination ("IME") was performed on Petitioner by Dr. Brian J. Cole ("Dr. Cole"). (Pet. Ex. 8). Upon reviewing Petitioner's medical records and examining the Petitioner, Dr. Cole concluded: (1) that based upon the fact pattern provided by claimant and the injury, Petitioner suffered an aggravation of a preexisting, mild-to-moderate osteoarthritis that now warranted treatment; (2) that Petitioner should go forward with the series of viscosupplementation injections as recommended by Dr. Redondo; (3) that if injections were unsuccessful, an arthroscopy should be conducted; and (4) that Petitioner had not yet reached MMI. (Id. at 8:2-3). At his evidence deposition, Dr. Cole testified that while he believed an arthroscopy would be the more prudent next step in Petitioner's treatment, the "ultimate fix" would be knee replacement – which would have to inevitably happen at some point in Petitioner's life. (Pet. Ex. 9:21-23).

On November 2, 2016, Petitioner returned to Dr. Redondo for a sixth follow-up, with no new plans to be implemented as he was waiting for the IME report to become available. (Id. at 5:13-15). The work status form resulting from this visit reflect Petitioner's availability to return to work with modified duty, but the specific restrictions previously listed were no longer indicated. (Id. at 5:50).

On February 2, 2017, Petitioner had her seventh follow-up visit with Dr. Redondo, where the first Orthovisc injection was administered. (Id. at 5:16). The remaining three injections took place on February 9th, 16th, and 22nd respectively. (Id. at 5:16, 19 - 23). Upon completion of the injections, on March 22, 2017, Petitioner returned to Dr. Redondo to check on her progress. (Id. at 5:24 – 26). It was noted that Petitioner had not improved with the injections – noting the continued presence of pain and stiffness within the knee joint. (Id.). It was further noted that Petitioner still had neither underwent a course of physical therapy nor obtained a brace for the knee. (Id.). Petitioner's work status form from this visit continued to permit modified work duty, but delineated restrictions on the work which could be performed – with continuous sitting required. (Id. at 5:52).

At Petitioner's follow-up with Dr. Redondo on April 5, 2017, Dr. Redondo recommended that the only treatment left to Petitioner was a right total knee replacement and that Petitioner wished to proceed with the surgery. (Id. at 5:27-29). Petitioner's work status form reflected Dr. Redondo's updated conclusions from the appointment – specifically recommending a right total knee arthroplasty, but adding restrictions that Petitioner could not kneel, twist, squat or perform overhead work. (Id. at 5:53). Dr. Redondo testified at his evidence deposition that knee replacement surgery, despite being last resort procedure, was necessary for the Petitioner as a knee arthroscopy would be a "waste of her time". (Pet. Ex. 10:49-51).

On April 19, 2017, Petitioner received correspondence from Bud's Ambulance informing her that her management status was temporarily being removed in order to accommodate the light duty work restrictions. (Pet. Ex. 7). Petitioner continued working for Respondent until October 8, 2019, upon which she was informed by the Respondent's human resource representative that light duty was no longer available and to not return to work. (Trans. p.17-18). Respondent did not indicate whether Petitioner was discharged from employment, but Petitioner has not returned to work since that date. (Id. at 19).

Petitioner had prior medical issues with her right knee prior to her work injury on January 22, 2016. Petitioner's underwent a right knee arthroscopy in approximately 1994. (Pet. Ex. 8:1; Trans. p. 21; Pet. Ex. 3:3).

In 2008, Petitioner suffered a work-related accident that led to a second right knee arthroscopy in April 2009. (Id.). In July 2009, Petitioner required an anterior medialization of the tibial tuberosity for persistent pain and patellar instability. (Id.) Petitioner was noted to have made a full recovery from those injuries with no significant sequelae through January 22, 2016 and had not been under active care of a doctor for the knee. (Id.).

Petitioner testified that she currently and consistently has right knee pain that has affected her daily life activities. Specifically, Petitioner indicated that the her back and gait have become detrimentally affected due to her shifting weight from her affected knee. (Id. at 20).

Respondent introduced evidence at trial purportedly illustrating Petitioner's involvement in a charity event called Polar Plunge for Special Olympics. (Resp. Ex's. 3, 4; Trans. p. 28-29). Petitioner testified that involvement in this event would be to obtain charitable donations, after which she would enter a body of water during a cold time of year. (Resp. Exs. 3; Trans. 26-27; 35-36). Respondent entered into evidence photographs taken of the Petitioner participating in the event – the date of said pictures having not been established at trial. (Resp. Ex. 4). Petitioner testified that participation in the "plunge" part of the event involved her and her children walking in Manteno Lake, walking toward divers standing approximately twenty-five feet from the shore, then turning around and walking back to shore. (Trans. 35-36). Petitioner testified that while there are other participants who would run into the lake, it was not a race, and that she never ran into the water. (Id. at 30-31, 35-36).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law which immediately follow:

(C) Causal Connection

The Arbitrator finds that Petitioner's current condition of ill-being is casually related to the injury sustained on January 22, 2016.

Petitioner carries the burden of proving her case by a preponderance of the evidence. *Parro v. Industrial Commission,* 630 N.E.2d 860 (1st Dist. 1993). In cases where the existence of a preexisting condition is present, recovery will depend on the employee's ability to show that a work-related injury 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. v. Industrial Comm'n,* 207 Ill. 2d 193, 203 (2003), *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill.2d 30 (1982). Recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Id.* at 205. Whether a claimant's disability is attributable solely to a degenerative process of the preexisting condition or to an aggravation or acceleration of a preexisting condition because of an accident is a factual determination to be decided by the Commission. *Id.*; *Roberts v. Industrial Comm'n,* 93, Ill.2d 532, 538 (1981).

There is no dispute between the parties that Petitioner had a preexisting condition involving her right knee prior to her work injury on January 22, 2016. Her first surgery was when Petitioner was approximately 18 years old and consisted of an arthroscopy. (Trans. p. 21; Pet. Ex. 3:3). The second surgery was in April 2009, and a third surgery in July 2009. (Pet. Ex. 8:1). The second and third surgeries were due to a work-related injury, and an Application for Adjustment of Claim was previously filed and resolved before the Commission. (Trans. p. 21; *Duzakowitcs v. Bud's Ambulance Service*, 09-WC-8206).

Both Dr. Redondo and Dr. Cole testified that knee replacement surgery is required for Petitioner. (Pet. Ex. 5:27-29); Pet. Ex. 9:21-23). The only difference in opinion between the physicians is when the surgery should take place. While Dr. Cole testified at his deposition that he would do everything else in his power, short of surgery, to help alleviate Petitioner's symptoms, he nevertheless acknowledged that Petitioner requires the knee replacement. (Pet. Ex. 9:21-23). Dr. Cole further testified that Petitioner's symptoms were worsened as a result of the injury in question and was as reaggravation of a work related, preexisting condition. (Pet. Ex. 8:3). Dr. Cole acknowledged that Petitioner, "certainly had some level of preexisting condition that was not symptomatic

enough to need treatment between 2009 and January 2016." (Id.) Petitioner testified that she had ran three times on the date of the accident between the patient and the ambulance, and pointedly stated that she does not run in the Polar Plunge (Trans. pp. 10, 30). She also offered additional testimony tied to the continued degenerative nature of her condition. (Id. at p. 20). This testimony, applied to Drs. Cole and Redondo's opinions, make it clear that the injury Petitioner received on January 22, 2016 caused the symptoms to knee pain to occur, and undoubtedly advanced the possible timetable for the knee replacement surgery – thus satisfying the causal connection element of Petitioner's case.

The Arbitrator did not find Respondent's claim that Petitioner's participation in a charitable Polar Plunge event damaged Petitioner's credibility. No foundation evidence was submitted as to the date Petitioner was involved in the event – and therefore the Arbitrator cannot reasonably rely on the event's temporal proximity to the date of injury in this case. Notwithstanding, Petitioner credibly testified that when she would participate in the event, she would not run, but instead would walk in and out of the water. There was no testimony that she normally engaged in physical activity which would have been counter-indicative of her physical condition described in the various medical reports. Since Petitioner was not precluded from walking as a result of her injuries, it is not persuasive that her participation in this event damages her credibility.

(K) TTD

The Arbitrator repeats the findings set forth in support of (C), as if set forth fully herein.

Parties stipulated that an accidental injury was sustained on January 22, 2016. Per multiple work status forms prepared by Dr. Redondo and given to the Respondent, Petitioner was placed on light work duty from January 22, 2016 through October 8, 2019. On October 8th, Petitioner was informed by Respondent's human resources officer that light duty was no longer available. Petitioner continued to have light duty restrictions, and based upon testimony provided, Petitioner appears to still be an employee of Respondent. Given that the Petitioner has not reached MMI – a conclusion supported by both Dr. Redondo and Dr. Cole - the Respondent is responsible for payment of temporary total disability benefits.

The Arbitrator finds that Petitioner is owed Temporary Total Disability ("TTD") benefits from October 9, 2019 through January 15, 2020 for a total 14 weeks at the TTD rate of $588.47 per week. Petitioner is therefore entitled to recover from the Respondent the sum of $8,238.58.

(O) Prospective Medical

The Arbitrator repeats the findings set forth in support of (C) and (K), as if set forth fully herein.

Petitioner seeks right knee replacement surgery. Both her treating physician, Dr. Redondo, and the Respondent's IME, Dr. Cole, agree that Petitioner's case necessitates a right knee replacement surgery. Dr. Redondo agreed at deposition that the only thing which could cure Petitioner's condition of ill-being would be a total knee replacement. (Pet. Ex. 10:25-26). Dr. Cole similarly agreed that the "ultimate fix" would be a knee replacement – which would have to happen at some point in her life. (Pet. Ex. 9:22). The physicians further agreed that the determination of whether to have the surgery now as opposed to later is Petitioner's "misery factor", stating, "if she is inexorably miserable and everything else has failed, then it could be an option". (Id. at. 9:13-14). Dr. Cole acknowledged that Dr. Redondo's preference for knee-replacement as opposed to a knee arthroscopy is not wrong, and properly offered if Dr. Redondo believed that the arthroscopy would not help. (Id.). This is the exact conclusion offered by Dr. Redondo, who stated that an arthroscopy would be a waste of Petitioner's time. (Pet. Ex. 10:49-51).

Petitioner testified that her right knee pain was severe enough that she wanted to have the total knee replacement, and that she was waiting for approval so as to undergo the surgery. (Trans. at 19-20). The Arbitrator found the Petitioner credible that it was her desire to undergo the knee replacement surgery, and that based upon

her testimony, records, and opinions of Drs. Redondo and Cole, that knee replacement surgery is required to address her condition.

Therefore, the Arbitrator orders Respondent to provide and pay, per the fee schedule, for the total knee replacement for the right knee and all ancillary treatment, maintenance or institutional care that is required for the operation and recovery therefrom.

Signed: _____ 3/13/2020

SIGNATURE OF ARBITRATOR DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005865
Case Name	HUDSON, TINIKA v. MANORCARE HEALTH SERVICES - HINSDALE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0146
Number of Pages of Decision	28
Decision Issued By	Kathryn Doerries, Commissioner, Kathryn Doerries, Commissioner

Petitioner Attorney	Martha Niles
Respondent Attorney	Daniel Flores

DATE FILED: 4/18/2022

/s/Kathryn Doerries, Commissioner

Signature

DISSENT

/s/Kathryn Doerries, Commissioner

Signature

22IWCC0146

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TINIKA HUDSON,

Petitioner,

vs. NO: 19 WC 005865

MANORCARE HEALTH SERVICES,

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 benefit rates, wage calculations, causal connection, medical expenses, reasonableness of medical charges, necessity of medical treatment, temporary disability, permanent disability, §19(k) and §19(l) penalties and §16 attorney's fees, the age of Petitioner and the number of Petitioner's dependents, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's award as referenced herein and affirms the award except regarding the issues of causation, medical expenses, temporary total disability (TTD), permanent partial disability, (PPD), and §19(l) penalties, for the following reasons.

Causation

The Commission agrees with the Arbitrator's Order finding that Petitioner sustained trauma related permanent partial disability, however, disagrees with the Arbitrator's award of 15% loss of use of a left hand. The Commission finds that Petitioner failed to prove her pre-existing condition of carpal tunnel syndrome was caused or aggravated by the subject accident. Dr. Heller, the only hand and upper extremity orthopedic surgeon to examine Petitioner, opined

that the Petitioner did not have any evidence of carpal tunnel syndrome at the time of his examination. The Commission finds Dr. Heller's testimony is credible based on the Petitioner's initial medical complaints, the medical records and subsequent treatment, and Petitioner's testimony.

Medical Expenses

The Commission modifies the Arbitrator's award of medical expenses. The Commission modifies the Arbitrator's Order so that it now reads, "Respondent shall pay Petitioner's medical treatment as identified in Petitioner's exhibit 3, through May 31, 2019, excluding charges related to the Petitioner's diagnosis of carpal tunnel syndrome, pursuant to Section 8.2 and 8(a) of the Act, and subject to the fee schedule." The Commission further modifies the Arbitrator's Conclusions of Law on page nine of the Arbitrator's Decision, by modifying the last sentence, so it now reads, "As such, Respondent shall pay Petitioner for the medical treatment Petitioner received from AMCI, EQMD and Preferred MRI, as identified in Petitioner's exhibit 3, excluding charges for services related to Petitioner's carpal tunnel syndrome, including but not limited to the April 15, 2019 EMG/NCV and April 22, 2019 injection, pursuant to Sections 8.2 and 8(a) of the Act, and subject to the fee schedule."

Temporary Total Disability

The Commission modifies the Arbitrator's award of TTD by correcting a scrivener's error. The Arbitrator's Decision includes the following Order: "Respondent shall pay Petitioner, TTD benefits from February 27, 2019 through May 6, 2019, for a period of 7-5/7 weeks at the statutory minimum temporary total disability rate based upon having four dependent children, as set forth in the Conclusions of Law attached hereto and incorporated herein." The Commission agrees that Respondent shall pay TTD for the referenced period, February 27, 2019, through May 6, 2019, however, however, this period equals 9-6/7 weeks. Therefore, the Commission modifies the Arbitrator's award by correcting this scrivener's error. The TTD award will now read, "Respondent shall pay Petitioner TTD benefits from February 27, 2019 through May 6, 2019, for a period of 9-6/7 weeks at the statutory minimum temporary total disability rate based upon having four dependent children, as set forth in the Conclusions of Law attached hereto and incorporated herein."

Permanent Partial Disability

The Commission agrees with the Arbitrator's Order finding that Petitioner sustained trauma related permanent partial disability (PPD), however, disagrees with the Arbitrator's award of 15% loss of use of a left hand. The Commission finds that Petitioner sustained trauma related permanent partial disability to the extent of 5% loss of use of a left hand. Therefore, the Commission strikes the Order in the Arbitrator's Decision related to the award of PPD, and strikes the Arbitrator's Conclusions of Law in the Section "L" , "With respect to issue "L," the nature and extent of Petitioner's injuries, the Arbitrator makes the following conclusions:" With respect to issue "L," the Commission substitutes the following Conclusions of Law:

According to Section 8.1b(b) of the Act, for injuries that occur after September 1, 2011, in determining the level of permanent partial disability, the Commission shall base its

determination on the following factors:

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

In considering the degree to which Petitioner is permanently partially disabled as a result of the work-related accident, the Commission weighs the five factors in Section 8.1b(b) of the Act as follows:

(i) No AMA impairment rating was submitted by either party, so this factor is given no weight.

(ii) Petitioner was employed as a Certified Nursing Assistant and she subsequently returned to work at a different employer in this capacity. Petitioner did find work as a wound technician thereafter, which Petitioner described as less physically demanding. This factor is assigned greater weight.

(iii) Petitioner was 39 years old at the time of the accident and has a substantial amount of work life remaining until retirement. This factor is assigned some weight.

(iv) The Petitioner is being paid more money per hour than she was paid for Respondent. There is no evidence of reduced future earning capacity in the record thus this factor is assigned some weight.

(v) Regarding evidence of disability corroborated by the treating medical records, as a result of the work-related accident of February 9, 2019, Petitioner reported an injury to her left ring finger on the date of accident. She reported that three fingers were bent back. The initial diagnosis at Concentra on the date of accident was a strain of the left middle, ring and index fingers. She cancelled her appointment on February 11, 2019. On February 14, 2019, her history reflects she reported pain of 4/10 in all three fingers. The therapy notes at Concentra on February 22, 2019 show the evaluation was for a strain of the left middle finger. On the day that Petitioner switched providers to ACMI, almost three weeks after the date of accident, and after multiple visits to Concentra, the Petitioner's accident history changed to include not only the initial description of being grabbed by her left middle, index and ring fingers but also that the patient "bent her wrist bent backwards and wrenched her hand." Petitioner received chiropractic treatment, physiatrist care, treated with opiates, and also treated for an unrelated carpal tunnel condition. Petitioner was off work 9-6/7 weeks, from February 27, 2019, through May 6, 2016.

Petitioner testified at Arbitration she continues to experience difficulties lifting, weakness, persisting pain with grabbing and gripping. However, the Commission notes that Petitioner has not received medical treatment since May of 2019, two years

> before the hearing, nor was she assigned permanent work restrictions. The Commission gives this factor greater weight in determining permanent partial disability

Based upon the foregoing factors, the entire record, including, but not limited to, the testimony, medical records and all of the exhibits, the Commission finds that Petitioner sustained trauma related permanent partial disability to the extent of 5% loss of use of a left hand, (10.25 weeks) pursuant to §8(e)(9) of the Act.

Penalties and Fees

The Commission affirms and adopts the Arbitrator's award of § 19(k) penalties and §16 fees on unpaid medical bills except those related to the Petitioner's carpal tunnel condition in Petitioner's Exhibit 3, however, the Commission reverses the Arbitrator's award of §19(l) Penalties. Therefore, the Commission strikes all references to §19(l) penalties in the Conclusions of Law, in the section entitled, "With respect to issue "M", should penalties or fees be imposed upon Respondent." The Conclusions of Law under issue "M" should instead include the following:

§19(l) of the Act provides, in pertinent part, as follows:

> (l) If the employee has made written demand for payment of benefits under Section 8(a) [*820 ILCS 305/8*] or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d) [*820 ILCS 305/8.2*]. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19*

There is no evidence in this record that the Petitioner made a written demand for payment of either TTD or for payment of medical bills as required by §19(l). *Theis v. Ill. Workers' Comp. Comm'n*, 2017 IL App (1st) 161237WC, 74 N.E.3d 468, 2017 Ill. App. LEXIS 145, 412 Ill. Dec. 1.

A review of the bills in Petitioner's Exhibit 3 confirms that the Concentra bills were paid. The South Holland Medical Center's first Billing Statement shows that the bills for services provided by Dr. Najera in April and May 2019 were billed to Petitioner. It appears that explanation of benefits (EOBs) from services provided by Dr. Najera, the chiropractors Hooton, Patel and Dale and billing statements issued by Dr. Foreman billed by AMCI or EQMD were

addressed to the Respondent at the P.O. Box in Toledo, Ohio, however, the MRI EOB, was addressed to the Petitioner's attorney's law firm. The attorneys did not exchange exhibits before trial. (T. 7-8)

The *Thies* court explained the significance of tendering the bills to the employer for payment:

> The act of submitting medical bills into evidence during arbitration is not the same as tendering them to the employer for payment. In addition, claimant cites no authority, nor does our research reveal any, which stands for the proposition that an employer has a duty to actively seek out a claimant's medical bills either through the use of a subpoena or some other method in order to comply with the requirements of section 19(*l*). *Theis v. Ill. Workers' Comp. Comm'n*, 2017 IL App (1st) 161237WC, P23, 74 N.E.3d 468, 472, 2017 Ill. App. LEXIS 145, *10, 412 Ill. Dec. 1, 5

It was never established that the Petitioner made a demand for payment of the medical bills in writing, or provided the medical bills to Respondent with a demand for payment of the unpaid medical bills in writing prior to the hearing. Therefore, based upon the afore-referenced reasons, the Commission declines to award §19(l) penalties.

Finally, the Commission denies Petitioner's Motion to Strike Portions of Petitioner's Brief.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on July 21, 2021, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week, the statutory minimum temporary total disability rate based upon having four dependent children, for a period of 9-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week, the statutory minimum permanent partial disability rate based upon having four dependent children, for a period of 10.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 5% of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for the medical expenses for Petitioner's medical treatment received from AMCI, EQMD and Preferred MRI, as identified in Petitioner's exhibit 3, excluding charges related to the Petitioner's carpal tunnel syndrome condition which, therefore, excludes charges that include, but are not limited to, the charges for the April 15, 2019 EMG/NCV and April 22, 2019 injection, and subject to the fee schedule pursuant to §8.2 and §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner penalties pursuant to §19(k) equal to 50% of the unpaid medical bills and 50% of the unpaid TTD

and attorney's fees pursuant to§16 on all of the penalties and amounts awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Strike Portions of Respondent's Brief is denied.

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

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

Bond 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.

April 18, 2022

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/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell* _
Thomas J. Tyrrell

DISSENT

I concur with the majority opinion regarding modification of the Arbitrator's Decision in all respects except for the award of §19(k) penalties and § 16 attorney's fees.

Section 19(k) provides:

> In case [*sic*] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. *820 ILCS 305/19(k)* (West 1992).

According to section 16,

> Whenever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier. *820 ILCS 305/16 (West 1992).*

The Illinois Supreme Court explained the distinction between the standards for an award under §19(l) and §19(k) penalties as follows:

> [W]e first note our agreement with the Commission's view that imposition of section 19(k) penalties and section 16 attorney fees requires a higher standard than an award of additional compensation under section 19(l). Although all three provisions refer to unreasonable delay, the standard under section 19(l) must differ from that set forth in section 19(k) and repeated in section 16. Otherwise, whenever there was an "unreasonable delay" for purposes of section 19(l) there would automatically be an "unreasonable delay" for purposes of section 19(k). The two provisions would essentially be redundant.
>
> Viewing the statute as a whole, we believe that section 19(k) and section 19(l) were actually intended to address different situations. The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.
>
> In contrast to section 19(l), section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory. See *Smith v. Industrial Comm'n*, 170 Ill. App. 3d 626, 632, 121 Ill. Dec. 275, 525 N.E.2d 81 (1988). The statute is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms "vexatious," "intentional" and "merely frivolous." Section 16, which uses identical language, was intended to apply in the same circumstances.

McMahan v. Indus. Comm'n (farmer's Elevator), 183 Ill. 2d 499, 514-515, 702 N.E.2d 545, 552-553, 1998 Ill. LEXIS 1572, *23-25, 234 Ill. Dec. 205, 212-213.

In this case, the majority agrees that there was no evidence of unreasonable delay as intended by §19(l) penalties for late payment of medical and TTD benefits. Without a written demand for payment of the medical bills, for purposes of §19(l) penalties, Petitioner has failed to sustain her burden of proof. Therefore, Respondent had "good and just cause" for non-payment of the medical bills. Further, even Dr. Heller's opinion, was, in part, based on Petitioner's history that her hand was bent at the time of accident, a fact that was not consistent with Petitioner's initial histories for more than two weeks. Nonetheless, Dr. Heller found no evidence of carpal tunnel syndrome, thus the treatment after Concentra could still be construed as to be unrelated to the three finger sprain. It is obvious that Respondent relied on the accident report and the initial histories at Concentra, confirming that Petitioner had sustained solely a strain of three fingers as a result of the subject incident. Further, there was no reason, based on her initial treatment, that Petitioner could not continue to do light-duty work and the dispute thereafter regarding her ability to work light duty was legitimate based on the following.

The initial Concentra Employer Services Injury Care Form documents the following history, "I was asst. a pt and he grabbed my 3 fingers really hard and twisted them and I felt a pop and then burning in my ring finger." The part of the body injured was listed as "Ring finger on my left hand." (PX2) The Concentra medical office note on February 9, 2019, confirms that Petitioner's chief complaint was an injury to her left ring finger. An x-ray was taken of her left ring finger confirming the following: "Findings: …Middle and proximal phalanges obscured on the lateral. No noted fracture or dislocation by 2 views. Mineralization is normal. Joint spaces normal." The Impression confirmed: "No acute osseous finding by 2 views." Under Review of Systems, Musculoskeletal, Petitioner reported joint pain, joint swelling and joint stiffness. Under Review of Systems, Neurological, she reported numbness. Thus, Petitioner had some non-described, pre-existing complaints. The evaluation was for a strain of left middle finger. (PX2) The diagnosis was strain of left middle, left ring and left index fingers. *Id.* On February 14, 2019, the Concentra Recheck Injury Flowsheet documents that Petitioner cancelled her February 11, 2019, appointment. *Id*. At the February 14, 2019, encounter, her HPI documents that she reported her pain was 4/10 in all 3 fingers. A handwritten note on February 21, 2019 at Concentra indicates she reported numbness and tingling, her BMI was 41.6 and it was noted that she was a former smoker. The Concentra therapy records dated February 21, and February 22, 2019, document that Petitioner reported that she had 0 out of 10 on the pain scale. *Id.* The February 22, 2019, physical therapy record at Concentra shows that her evaluation was for a strain of left middle finger. During exercises, Petitioner had a complaint of pain in her volar wrist.

Petitioner's treatment at Concentra was paid (PX3) and Respondent provided light duty work up until February 26, 2019. The Concentra records included a letter to the Emergency Medical Center Representative from Human Resources at Manor Care, indicating that Transitional duty positions are always available for employees unable to return to regular duties and asked that the medical provider indicate any restrictions and/or guidelines recommended for the employee. (PX2) February 27, 2019, coincided to the date that Petitioner's Application for Adjustment of Claim was filed and the date she switched medical providers.

According to the initial treating records at ACMI on February 27, 2019, Petitioner began treating with a chiropractor thereafter for a new, primary complaint of left wrist and hand pain.

Petitioner also reported that she had been working restricted duties, but told the chiropractor that her employer was not consistently complying with the restrictions. (PX2) This statement, an uncorroborated accusation was, more importantly, contrary to Petitioner's own testimony. In fact, Petitioner testified, "No" when asked if she continued to work for Respondent when she was treating at Concentra. (T. 22) This testimony is patently untrue, and the ACMI medical history was corroborated by the fact that Petitioner did not claim she was entitled to TTD during this period.

Footnote #5 in the Arbitrator's Decision evidences that the Arbitrator did not draw the same conclusion, i.e. that Petitioner's testimony was not true, and does not comport with the history in the ACMI medical records that she had been working restricted duties during the period February 10, 2019 through February 26, 2019. The ACMI initial history regarding Petitioner's working restricted duties up until that point ultimately explains the reason that TTD was not claimed from the day after the accident through February 26, 2019.

The Arbitrator's footnote #5, however, relies upon Petitioner's testimony, not the medical records, and highlights an unfavorable conclusion that Respondent would not accommodate light duty restrictions issued by Concentra. The #5 footnote states:

> Petitioner testified she was issued light duty restrictions by Concentra which Respondent would not accommodate. Petitioner did not claim an entitlement to TTD benefits from February 10, 2019 through February 26, 2019 in the Request for Hearing. (Arb. Ex. #1). As such, the Arbitrator is unwilling to award those TTD benefits because it was not a contested issue at trial.

The ACMI initial record on February 27, 2019, belies the Petitioner's testimony that the light duty restrictions were not being accommodated. Instead, Petitioner reported to the chiropractor that the employer was not complying with the restrictions, and the chiropractor provided Petitioner with an off-work slip thereafter. Thus, there was a legitimate dispute as to whether or not the Petitioner could work light-duty. According to the letter by human resources in the Concentra records, the Respondent could always accommodate light duty.

Thus, I disagree with the majority, that there is evidence that the delay in payment of both the medical bills and the TTD was the result of bad faith, improper purpose, vexatious or frivolous. I further disagree with my colleagues that there is justification for penalties under §19(k) penalties or §16 attorney's fees, a discretionary punishment requiring an assessment of all the circumstances, especially in the absence of an award of §19(l) penalties in the majority's opinion, which I wholeheartedly agree were not warranted.

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005865
Case Name	HUDSON, TINIKA v. MANORCARE HEALTH SERVICES
Consolidated Cases	
Proceeding Type	
Decision Type	Amended Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	18
Decision Issued By	Frank Soto, Arbitrator

Petitioner Attorney	Martha Niles
Respondent Attorney	Richard Lenkov

DATE FILED: 7/21/2021

THE INTEREST RATE FOR THE WEEK OF JULY 20, 2021 0.05%

/s/ Frank Soto, Arbitrator

Signature

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
AMENDED ARBITRATION DECISION

TINIKA HUDSON
Employee/Petitioner

v.

MANOR CARE HEALTH SERVICES
Employer/Respondent

Case # **19** WC **5865**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **May 17, 2021**. After reviewing all 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 **Number of Petitioner's Dependants**

FINDINGS

On **2/9/2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**28,704.00**; the average weekly wage was $**427.68**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **4** 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** 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 $**2,425.31** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner for the medical treatment Petitioner received from AMCI, EQMD and Preferred MRI, as identified in Petitioner's exhibit 3, pursuant to Sections 8.2 and 8(a) of the Act, and subject to the fee schedule, as set forth in the Conclusions of Law attached hereto and incorporated herein;

Respondent shall pay Petitioner TTD benefits from February 27, 2019 through May 6, 2019, for a period of 7 5/7 weeks at the statutory minimum temporary total disability rate based upon having four dependent children, as set forth in the Conclusions of Law attached hereto and incorporated herein;

Petitioner sustained trauma related permanent partial disability to the extent of 15% loss of use of a left hand, pursuant to §8(e)(9) of the Act, as set forth in the Conclusions of Law attached hereto and incorporated herein;

Respondent shall pay Petitioner penalties pursuant Section 19(l) the sum of $10,000.00 and penalties under Section 19(K) equal to 50% of the unpaid medical bills; 50% of the unpaid TTD and attorney's fees pursuant to Section 16 on all of the penalties and amounts awarded, , as set forth in the Conclusions of Law attached hereto and incorporated herein;

Respondent shall pay Petitioner compensation that has accrued from February 9, 2019 through May 17, 2021and 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.

___/o/ *Frank J. Soto* _____ **JULY 21, 2021**

Signature of Arbitrator

Procedural History

This matter proceeded to trial on May 17, 2021. The issues disputed are whether Petitioner sustained an accidental injury that arose out of and in the course of her employment; whether Respondent was given notice within the time limits provided in the Act; whether Petitioner was 39 years old and had 4 dependent children at the time of the accident; whether Petitioner's current condition of ill-being is causally connected to a work injury; whether Respondent is liable for medical bills and TTD benefits. The nature and extent of Petitioner's injury is at issue. A petition for penalties and attorney's fees pursuant to sections 19(k), 19(l) and 16 of the Act was also filed in this matter. (Arb. Ex. #1).

Findings of Fact

Petitioner's Testimony:

Tanika Hudson (hereafter referred to as "Petitioner") testified on February 9, 2019 she was employed by Manor Care Health Services (hereinafter referred to as "Respondent") as a CNA. (T. 13,14). Petitioner testified she is 41 years old and, on February 9, 2019, she had four children who resided with her. The children's names and ages are Keymani, age 19, Amarion, age 17, Ty'Rel, age 8 and Khalil, age 7. (T. 12)[1].

Petitioner testified her job duties as a CNA, included transferring patients to shower chairs, changing patient's briefs while they were in bed, and feeding patients. Petitioner testified, on February 9, 2019, she was assisting another CNA with a combative patient who grabbed the three fingers of Petitioner's left hand and twisted them backwards. Petitioner testified as the patient twisted her fingers back, she felt a popped in her left wrist and a stinging and hot sensation. (T. 16).

Petitioner testified she screamed for help and the on-call nurse arrived and pried, with the assistance of another CNA, Petitioner's fingers free. (T. 17). Petitioner testified she reported the incident to the supervising nurse who assessed Petitioner's left hand, provided Petitioner an ice pack and an injured worker's packet. (T. 18). One of the documents contained in the injured worker's packet with the heading "Local Contacts" was entered into evidence as Petitioner's Exhibit No. 5. [2]

[1] Petitioner submitted into evidence, without objection, the birth certificates for her children. (Px. 1).

[2] Petitioner's Exhibit 5 identifies "*preferred Providers*" which directs injured workers to specific medical providers. The document states Concentra Convenient Care of Darien, as the first choice, Concentra Convenient Care of Bridgeview, as the second choice, and Hinsdale Hospital Emergency Room, as the third choice. The document also

Petitioner testified she initially treated with Concentra on February 9, 2019. (T. 20). Petitioner testified she switched treatment to AMCI on February 27, 2019. (T. 22). While treating at AMCI, Petitioner underwent physical therapy, a left wrist MRI and injection. (T. 21, 27). Petitioner was diagnosed with left carpal tunnel syndrome. Petitioner testified that prior to her February 9, 2019 work accident she was never diagnosed with left carpal tunnel syndrome nor had she experienced any left wrist symptoms. (T. 29).

Petitioner testified May 6, 2019 was she was referred to a specialist for a surgical consolidation. (T. 69). Petitioner testified that prior to seeing the specialist, she was underwent an independent medical examination and was told she could return to work without any restrictions. (T. 69). Petitioner testified after the independent medical examination she was not allowed to see the specialist and that she has not received any additional medical treatment for her left hand and wrist.

Petitioner testified in early March, she met with two ladies who worked in human resources, named Lisa and Theresa, who told her Respondent would not pay for Petitioner to see a second doctor and that she could only treat with Respondent's doctors. (T. 26). Petitioner testified she tried to return to light duty work but was told by Lisa that no light duty work was available. (T. 62, 63). Petitioner testified she was never paid TTD benefits. (T. 70). Petitioner testified she never returned to work for because Respondent would not accommodate her light duty restrictions and then her employment was terminated. (T. 62).

Petitioner testified she subsequent found employment with Meadowbrook Manor as a CNA but after two months she was having difficulties preforming her CNA job duties due to her left wrist symptoms. Petitioner testified she was still experiencing a loss of strength, pain, and numbness in her left hand. Petitioner was given the position of concierge. (T. 30, 31). Petitioner testified she worked at Meadowbrook for about 7-8 months before accepting a job at the University of Illinois, as a field worker. (T. 40, 41). As a field worker, Petitioner would travel various places and teach community members about nutrition. Petitioner testified she left that job in October of 2020 and moved to Mississippi to help take care of her sick mother. (T. 45, 46). Petitioner testified she works as wound technician in Mississippi and her position does

states the following: "*Hinsdale Hospital should be used only when Concentra facilities are closed or in a TRUE emergency. This helps control workers compensation costs.*" (Px. 5)

not require any pulling, pushing or lifting. (T. 33). Petitioner testified she works 37 hours a week and earns more money per hour than she earned for Respondent.

As to her current symptoms, Petitioner testified her left wrist is weak and it is hard to for her to perform things such as laundry, vacuuming and sweeping. Petitioner testified is difficult for her to pick up her disabled son who weighs between 50 and 60 pounds. Petitioner testified that she continues to experience pain in her left wrist that runs up to her elbow. (T. 34,35). Petitioner testified Respondent did not pay any of the MCMA medical bills or any medications. (T. 36).

The Arbitrator finds Petitioner's testimony credible.

Medical Treatment:

On February 9, 2019, Petitioner was treated at Concentra[3]. Petitioner reported that a patient had grabbed her fingers and bent them backwards. Petitioner's chief complaint involved a sharp pain in the volar aspect of the left hand. Petitioner was diagnosed with strains of the middle, ring and index fingers. Petitioner was prescribed physical therapy and light duty restrictions were issued. Petitioner treated with Concentra through February 21, 2019. (Px. 2).

On February 27, 2019, Petitioner started treating with AMCI located in South Holland Illinois. On that date, an examination noted a grade one wrist edema, weakness due to pain in extension flexion, radiocarpal joint tenderness and a positive Tinel sign. Petitioner was taken off work and physical therapy was recommended. On March 5, 2019, Petitioner was examined by Dr. Foreman, of AMCI, who noted sensory decrease at the base of the palm and mid finger volar aspect. Dr. Foreman diagnosed left wrist and hand sprains with possible nerve involvement. Dr. Foreman stated that Petitioner's diagnoses were casually related to her reported incident. (Px. 2).

While treating with AMCI, Petitioner also came under the care of Dr. Nejara who prescribed therapy, an MRI and EMG. The EMG was positive for mild carpal tunnel syndrome on the left. Dr. Nejara diagnosed left hand sprain, left wrist sprain, and left carpal tunnel

[3] On June 20, 2018 Concentra conducted a pre-employment examination of Petitioner who was found to be capable for working full duty. The pre-employment examination did not identify any complaints or issues involving Petitioner's left wrist. (Px. 2).

syndrome.[4] Dr. Nejara performed a steroid injection into Petitioner's left wrist and he referred Petitioner to a specialist for a surgical consolidation. (Px. 2).

Section 12 Report issued by Dr. Heller on June 17, 2019:

On May 31, 2019, Petitioner was examined by Dr. Heller pursuant to Section 12 of the Act. Petitioner provided a history of injuring her left wrist and fingers when a patient grabbing her hand and bending it backwards. Dr. Heller reviewed the medical records from Concentra, AMCI as well as an EMG and MRI. Dr. Heller opined Petitioner suffered sprains and/or contusions to the left wrist and hand which are causally related to her work accident. (Rx. 1).

Dr. Heller stated the EMG shows moderate left carpal tunnel syndrome but the carpal tunnel syndrome resolved after Petitioner received the steroid injection. Dr. Heller opined Petitioner's work injury did not "cause or permanently exacerbated" her carpal tunnel syndrome. In his report Dr. Heller wrote "*Yes, I believe treatment to date has been reasonable and necessary. This had included diagnostic testing as well as physical therapy. I also believe that Dr. Najera appropriately performed a carpal tunnel injection, although in my opinion the carpal tunnel syndrome was not caused by the incident in question*". Dr. Heller opined Petitioner reached MMI, could return to work without restrictions, and no additional treatment is warranted. (Px. 1).

Testimony of Dr. Heller:

Dr. Heller testified via evidence deposition on December 28, 2020. Dr. Heller testified Petitioner's medical treatment provided was reasonable and necessary. (Rx. 2, pg. 20). Dr. Heller was asked whether Petitioner's work accident of February 9, 2019 permanently or temporarily exacerbation her carpal tunnel syndrome. Dr. Heller responded he could not provide an opinion to that question in any degree of medical certainty. (Rx. 2, pg. 17).

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

[4] The medical records from Dr. Nejara do not contain a causation opinion for Petitioner's left carpal tunnel syndrome. The AMCI records contain an opinion from Dr. Forman that Petitioner's left wrist and hand sprains were related to her work incident. Dr. Forman's records reference the possibility of nerve involvement but, at that time, Petitioner was not diagnosed with left carpal tunnel syndrome. (Px. 2).

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).

Regarding issue "C", whether Petitioner sustain an accidental injury that arose out of and in the course of her employment, the Arbitrator finds as follows:

Under Illinois law it is axiomatic that a petitioner must establish that their injury arose out of and in the course of their employment. *Paganelis v. Industrial Comm'n*, 132 Ill.2d 468, 480 (1989). For an injury to "arise out of" employment, it must have 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. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989). Petitioner must show, through a preponderance of the evidence, that the injury was caused or aggravated by the work accident, and not simply a result of a normal daily activity. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 214 (2003).]

The Arbitrator finds Petitioner proved by the preponderance of the evidence that she sustained an accidental injury which arose out of and in the course of her employment by Respondent on February 9, 2019. Petitioner testified she was injured on February 9, 2019 when a patient grabbed her left fingers and bent them backwards. Petitioner's testimony was corroborated by the histories provided to various physicians. Petitioner testified she immediately reported the incident to the nurse on-call who assisted freeing Petitioner's hand from the grip of the patient and was provided an injury packet. Respondent proffer no witnesses or other evidence to rebut Petitioner's testimony.

Regarding issue "E", whether timely notice of the accident given to Respondent, the Arbitrator finds as follows:

The Arbitrator finds Petitioner has proved by the preponderance of the credible evidence that she provided Respondent notice of the accident within the time limits provided in the Act. Petitioner testified she immediate reported the incident to the on-duty nurse and, in early March, she discussed the incident with two ladies who worked in the human resources department. Petitioner testified Respondent provided her an injury packet, which her to Respondent's preferred providers. Petitioner initially sought treatment with one of Respondent's preferred

providers, which was Concentra located in Bridgeview. Respondent failed to proffer any witnesses or other evidence to rebut Petitioner's testimony.

Regarding issue "F" is Petitioners current condition of ill being caused related to the injury, the arbitrator finds as follows:

In pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the pre-existing 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 a pre-existing condition. *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill.2d 30, 36-37. 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. *General Electric Co. v. Industrial Comm'n,* 89 Ill.2d 432, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982). When an employee with a preexisting condition is injured in the course and of his employment the Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. *Sisbro, Inc. Industrial Comm'n*, 207 Ill.2d 193, 278 Ill.Dec. 70,797 N.E.2d 665, (2003). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator finds that Petitioner has proven by the preponderance of credible evidence that her current condition of ill being is causally related to her February 9, 2019 work injury.

Petitioner's treating physicians diagnosed a left hand and wrist sprains and opined that Petitioner's conditions were causally related to her work accident. Dr. Heller, who performed the Section 12 exam, also opined that Petitioner's left wrist and hand strains and/or contusions were causally related to her work accident of February 9, 2019.

The remaining issue involves whether Petitioner's work accident caused or aggravated her left carpal tunnel syndrome. Dr. Heller opined Petitioner's work accident did not cause or "permanently" aggravate Petitioner's left carpal tunnel syndrome. Dr. Heller testified, at the time of his examination, Petitioner's left carpal tunnel symptoms resolved due to the steroid injection she received. The Arbitrator finds Dr. Heller's opinion that Petitioner's carpal tunnel

syndrome was not "permanently" aggravated by Petitioner's work accident is based, in part, upon the absence of carpal tunnel symptoms at the time of his examination due to positive results derived from the recent steroid injection.

The Arbitrator does not find Dr. Heller's opinion regarding Petitioner's carpal tunnel syndrome not being "permanently" aggravated by the work accident persuasive because Dr. Heller never re-examined Petitioner so he would not have known whether the effects of the injection was permanent. Dr. Heller did know whether Petitioner's symptoms returned. The Arbitrator finds Dr. Heller's exam observations persuasive as to the lack of carpal tunnel symptoms only at the time of his examination. To assume the results of an injection would be permanent, without a reexamination or review of subsequent medical records or other factors, is nothing more than conjecture, speculation, or guess. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons give for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board*, 318 Ill. App. 3d 507 (First Dist. 2000).

Petitioner testified, prior to her work accident of February 9, 2019, she never experienced any left wrist symptoms nor undergone any medical treatment for the left wrist. On June 20, 2018, Petitioner underwent a pre-employment examination which found that Petitioner was capable to working full duty. The Arbitrator notes the pre-employment examination does not identify any issues involving Petitioner' left wrist or hand. (Px. 2).

The Arbitrator notes neither Drs. Najera nor Foreman opined Petitioner's carpal tunnel syndrome was caused by her work accident. Dr. Foreman opined Petitioner's left wrist sprain and hand sprains were causally related to her work accident and there was the possibility of nerve involvement. As such, Dr. Foreman's causation opinions are limited to the sprains. Dr. Najera diagnosed carpal tunnel syndrome but he did not opine that Petitioner's work accident caused her carpal tunnel syndrome.

The Arbitrator finds it is reasonable to infer from the evidence Petitioner had preexisting asymptomatic left carpal tunnel syndrome that was aggravated by her work accident of February 9, 2019, which temporarily resolved after receiving a steroid injection. The Arbitrator notes, on May 6, 2019, Dr. Najera did not issue additional work restrictions which is consistent with Dr. Heller's exam findings regarding the absence of carpal tunnel syndrome symptoms during his May 31, 2019 exam. Dr. Najera referred Petitioner to a hand specialist but a referral to a

specialist is not proof, in of itself, that additional medical treatment is warranted or that one's symptoms persist. The Arbitrator notes Petitioner did not seek additional medical treatment after May of 2019 and she returned to work as a CNA for approximately two months.

Petitioner testified after working for about two months as a CAN, her left-hand symptoms made it difficult for her to continue to perform the job duties. The symptoms Petitioner experienced, after returning to the work, appears to be the same or similar symptoms as Petitioner experienced after her February 9, 2019 work accident and that she continued to report throughout her treatment. To assume the symptoms Petitioner was experiencing were only related to the carpal tunnel syndrome is nothing more than conjecture, speculation, and guess. Just as liability for benefits cannot be based on guess, speculation or conjecture nor should the denial of benefits. *See generally, Illinois Bell Telephone v. Industrial Commission*, 265 Ill. App.3d 681, 638 N.E.2d 207 (1994).

Regarding issue "J", Petitioner's age at the time of the accident and issue "O" the number of dependents Petitioner had on the date of injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner demonstrated she was 39 years old and had four dependent children on the date of her work accident. Petitioner testified she is currently 41 years old. In the Request of Hearing, Petitioner stated she was 39 years old at the time of her work accident which is supported by Petitioner's medical records and her pre-employment examination. Petitioner testified she had four children, who resided with her on the date of the work accident, and she submitted into evidence copies of her children's birth certificates. As the date of injury, Petitioner's eldest child, Keymani Jermaine Hudson, was 17 years and five months. The Arbitrator finds Petitioner's four children were legally dependent upon Petitioner on the date of injury.

With Respect to Issue "J", Whether Respondent is liable for Medical Expenses, the Arbitrator Finds as Follows:

Section 8(a) of the Act states a Respondent is responsible "…*for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury…"* A claimant has the burden of proving that the medical services were necessary, and the expenses were reasonable. See *Gallentine v. Industrial Comm'n*, 201 Ill.App.3d 880, 888 (2nd Dist. 1990).

The Arbitrator finds Petitioner proved by the preponderance of the evidence the medical treatment was reasonable and necessary to cure or relieve her from the effects of her work-related condition. Dr. Heller, in his report dated June 17, 2019, found Petitioner's medical treatment through the date of his May 31, 2019 examination was reasonable and necessary. Despite Dr. Heller issuing a report finding the medical treatment reasonable and necessary, Respondent continued to refuse to pay the medical bill from Preferred MRI, EQMD and AMCI. Respondent proffered no witnesses or other defense for their failure to pay the medical bills. As such, Respondent shall pay Petitioner for the medical treatment Petitioner received from AMCI, EQMD and Preferred MRI, as identified in Petitioner's exhibit 3, pursuant to Sections 8.2 and 8(a) of the Act, and subject to the fee schedule.

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

Petitioner seeks 7 5/7 weeks of TTD benefits from February 27, 2019 through May 6, 2019. (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).

The Arbitrator finds Petitioner proved by the preponderance of the evidence she is entitled to 7 5/7 weeks TTD benefits from February 27, 2019 through May 6, 2019. Petitioner testified she was never paid any TTD benefits. The AMCI medical records show that Petitioner was taken off work from February 27, 2019 through May 6, 2019.[5] As such, Respondent shall

[5] Petitioner testified she was issued light duty restrictions by Concentra which Respondent would not accommodate. Petitioner did not claim an entitlement to TTD benefits from February 10, 2019 through February 26, 2019 in the Request for Hearing. (Arb. Ex. #1). As such, the Arbitrator is unwilling to award those TTD benefits because it was not a contested issue at trial.

Pay Petitioner TTD benefits from February 27, 2019 through May 6, 2016 for 7 5/7 weeks. Based upon the stipulated average weekly wage of $427.68 and that Petitioner had four dependent children, the statutory minimum temporary total disability rate is $330.00 per week.

With respect to issue "L," the nature and extent of Petitioner's injuries, the Arbitrator makes the following conclusions:

Section 8.lb of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability.
>
> In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of Section 8.lb(b), the reported level of impairment pursuant to Section 8.1b(a), the Arbitrator notes that neither party submitted into evidence

an AMA impairment rating. Thus, the Arbitrator considers the parties to have waived their right to do so and assigns no weight to this factor.

With regard to subsection (ii) of Section 8.lb(b), the occupation of the injured employee, the Arbitrator notes that Petitioner was employed as a CNA. Petitioner attempted to return to work as a CNA but she experienced difficulties performing the work due to her ongoing symptoms. Petitioner found a different employment as a wound technician which is a less physically demanding position as a CNA. As such, the Arbitrator *greater* weight to this factor in determining permanent partial disability.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 39 years old at the time of the accident. Because of the anticipated length of her work life, the Arbitrator gives this factor *greater* weight in determining permanent partial disability.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner testified she is being paid more money per hour then she was paid for Respondent. Petitioner proffered no evidence that her future earnings have been impaired. As such, Arbitrator gives no weight to this factor in determining permanent partial disability.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, Petitioner testified that she continues to experience difficulties lifting, weakness, persisting pain with grabbing and gripping which are complaints well documented throughout Petitioner's treatment. The Arbitrator notes that Petitioner has not received medical treatment since May of 2019 nor does she have permanent work restrictions. As such, the Arbitrator gives this factor *some* weight in determining permanent partial disability.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained trauma related permanent partial disability to the extent of 15% loss of use of a left hand, pursuant to §8(e)(9) of the Act.

With respect to issue "M" should penalties or fees imposed upon Respondent; the arbitrator finds as follows:

The Arbitrator finds that Respondent is liable to pay Petitioner penalties pursuant to Sections K and L of the Act. The Arbitrator bases this finding on the following:

Section K states in relevant part:

> In cases where there has been any unreasonable or vexatious delay of payment… Or proceedings have been instituted or carried on by the one liable to pay compensation, which to not present a real controversy, but are merely frivolous or for delay, and the commission may award compensation additional to that otherwise payable under this act equal to 50% of the amount payable at the time of such award.
> . . . Failure to pay compensation in accordance with provisions of section 8 paragraph b of this act shall be considered unreasonable delay. . . .

Section L lays out that failure to pay benefits or delay benefits under section 8(a) or (b) can be penalized by the cost of $30 per day for each day at such benefits were withheld will be awarded, not to exceed $10,000; and that a delay of 14 or more days creates a rebuttable presumption of unreasonable delay.

Section 8A of the Act specifies that:

> . . . .The employee made at any time elect to secure his own physician surgeon and hospital services at the employer's expense or, upon agreement between the employer and employees… And subject to the approval of the Illinois Worker's Compensation commission… The employer shall maintain a list of physicians to be known as a panel of physicians.

The Act also provides that Respondent must pay for the injured worker's is first choice of doctor and the second choice of doctor, plus any doctors or any treatment within the chain of referral from those two doctors. However, if the employer has an approved panel of physicians, that will constitute a choice of doctors.

In the instant case, Dr. Heller, Respondent's Section 12 examiner, opined Petitioner's medical treatment was reasonable and necessary. Despite Respondent's Section 12 examiner finding Petitioner's medical treatment reasonable and necessary, Respondent continued to refuse paying the medical bills. Respondent proffered no explanation or justification for the continued refusal to pay the medical bills.

Petitioner testified she was told by Lisa and Theresa, who work in human resources, Respondent would not allow her to see a second doctor and Respondent would only pay the

medical bills for their preferred doctors. (T. 26). Petitioner was provided package of information which contained a document entitled "local Contracts". This document listed "Preferred Providers" which Concentra was one of them. (Px. 5). Concentra was the only medical bill Respondent paid. Respondent proffered no reasonable defense supporting their refusal to pay the medical bills.

The Arbitrator finds Respondent's failure to the medical bills supports Petitioner's testimony that Respondent told Petitioner she was not allowed to see any doctors other than their doctors and Respondent would only pay for treatment received from one of their doctors. It appears that Respondent was attempting to prohibit Petitioner from exercising her rights under the Act and/or to punish Petitioner for not treating with Respondent's "Preferred Providers". Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay and the standard the employer is held to is of an objective reasonableness in his belief. *Board of Education v. Industrial Comm'n*, 93 Ill.2d 1, 442 N.E.2d 861 (1982). In this case, Respondent proffered no reasonable basis for their denial of Petitioner's benefits.

Section 8(B) of the Act provides that if a petitioner loses more than three days from work as a result of the work injury, commencing on the fourth day, TTD would be due and owing. Further, if the disability lasted 14 or more days, the temporary total disability would go back to the first date it was due. Petitioner was issued work restrictions by Respondent's "Preferred Provider" Concentra on February 9, 2019. Respondent refused to accommodate Petitioner's restrictions and refused to pay Petitioner TTD benefits. Petitioner was taken off work from February 27, 2019 through May 6, 2019 and Respondent again refused to pay Petitioner TTD benefits.

Respondent's failure to pay medical bills, after the Section 12 examination, TTD benefits and was without good cause and, as such the Arbitrator finds that penalties, pursuant Section 19(l) are appropriate in an amount of the statutory maximum of $10,000.00.[6]

The Arbitrator further finds that penalties under Section 19(k) are also appropriate. Respondent refused to pay for the medical treatment, found to be reasonable and necessary by

[6] Respondent failed to pay medical bills after the 6/17/2019 IME for 700 days, from the IME report through the date of trial, and Respondent's failure to pay TTD benefits for 827 days from when those benefits were due through the date of trial.

Respondent's Section 12 examiner, because those providers were not on Respondent's list of "Preferred Provider" and/or to punish Petitioner for pursuing her rights under the Act. The Arbitrator finds Respondent's conduct to be deliberate, unreasonable and constitutes a vexatious delay in the payment of benefits. Clearly, if Respondent attempted to comply with the requirements of the Act, Respondent would have paid benefits after Respondent's Section 12 examiner's report was issued. Respondent proffered no witnesses or other evidence attempting to show that Respondent acted reasonably. Based on the foregoing, the Arbitrator award penalties in the amount of 50% of the unpaid medical bills; 50% of the unpaid TTD and attorney's fees pursuant to Section 16 on all the penalties and amounts awarded.

By: /o/ *Frank J. Soto* July 19, 2021
Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC026821
Case Name	MCLAIN, JAMES v. THE AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0147
Number of Pages of Decision	30
Decision Issued By	Christopher Harris, Commissioner, Deborah Baker, Commissioner

Petitioner Attorney	Bruce Wissore
Respondent Attorney	Julie Webb, Kenneth Werts

DATE FILED: 4/20/2022

/s/Christopher Harris, Commissioner

Signature

DISSENT

/s/Deborah Baker, Commissioner

Signature

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

JAMES MCLAIN,

Petitioner,

vs.

NO: 17 WC 26821

THE AMERICAN COAL COMPANY,

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 occupational disease, causal connection, and permanent partial disability (PPD) benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons outlined below. In summary, the Commission finds that Petitioner failed to prove that he suffers from the occupational disease of coal workers' pneumoconiosis (CWP) and further finds that Petitioner failed to prove that his alleged chronic bronchitis, COPD, impaired diffusion capacity, allergic rhinitis and postnasal drip conditions arose out of, and in the course of, or were related to his coal mine exposure while working for Respondent. As such, the Commission reverses the Arbitrator's Decision on these issues and strikes the award of five percent (5%) loss of the person as a whole in PPD benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission adopts and incorporates by reference the findings of fact contained in the Arbitrator's Decision, and additionally finds, expounds, and emphasizes as follows:

1) With the exception of two years, between 1983 and 1985, Petitioner had worked underground in the mines for 34 years; first as a laborer and then as a mine examiner. (T.10-11; T.13-24). He testified that he had been regularly exposed to and breathed pure coal dust, silica dust, roof bolting glue fumes and diesel fumes. (T.10-11).

2) Petitioner established that his last date of employment with Respondent was November 2, 2015. He testified that he had been laid off. (T.10-11; T.29). Petitioner was 56 years old at the time. (T.11).

3) Petitioner testified that he began noticing breathing problems toward the end while performing the mine examiner's job. (T.25). After Petitioner stopped working for Respondent, he stated that his breathing problems gradually worsened. (T.26-27).

4) Petitioner offered into evidence his medical records from Dr. Javier Muniz, his family physician. (T.27-28). An office visit note dated February 25, 2015 stated that Petitioner was following-up on his sepsis/pneumonia issues. Petitioner's symptoms had been moderate and acute but were now resolved. He was negative for any chronic cough, dyspnea, known TB exposure and wheezing. (PX3; RX4).

5) The next medical record that indicated any lung issue was dated February 17, 2017. Petitioner presented to Dr. Muniz with complaints of an ongoing cough with phlegm. The cough had started about a month prior, and he felt chest congestion and a sore throat. Petitioner was negative for dyspnea, dyspnea on exertion, hemoptysis, or hoarseness. The medical record indicated that Petitioner did not have a history of allergies or asthma. Chest x-rays were ordered. Petitioner was assessed with a chronic cough, and most likely, postnasal drainage. (PX3; RX4).

6) A chest x-ray taken on February 17, 2017, noted a comparison study dated February 8, 2015. The 2017 x-ray indicated mild accentuation of the perihilar lung markings not significantly changed from the prior exam and may represent a perihilar pneumonitis. Otherwise, there were no acute cardiopulmonary findings. A July 7, 2014 chest x-ray noted similar findings. (PX3; RX3).

7) Petitioner's subsequent visits to Dr. Muniz were unrelated to any breathing issues and pertained to annual visits or managing Petitioner's hyperlipidemia and hypertension conditions. A November 5, 2019 medical record indicated that Petitioner was negative for cough, chest tightness, shortness of breath, wheezing and stridor. Petitioner also had normal breath sounds, was not in respiratory distress and had no rales. (PX3).

8) On March 11, 2020, Petitioner presented to Dr. Muniz with a cough and congestion that had started 48 hours previously. Petitioner was positive for sinus pressure and cough, but negative for chest tightness, shortness of breath, wheezing and stridor. Pulmonary/chest effort and breath sounds were normal. Petitioner was not in respiratory distress and had no rales. He was diagnosed with acute bronchitis, unspecified organism. (PX3).

9) Petitioner returned to Dr. Muniz on March 24, 2020 to follow-up on his complaints of coughing from the previous March 11, 2020 visit. The medical record noted that Petitioner's coughing continued but that his congestion had subsided. Petitioner was again negative for chest tightness, shortness of breath, wheezing and stridor. Pulmonary/chest effort and breath sounds were normal. Petitioner was not in respiratory distress and had no rales. Petitioner was diagnosed with acute bronchitis, unspecified organism, and seasonal allergic rhinitis due to pollen. (PX3).

10) Petitioner next saw Dr. Muniz on July 22, 2020 for his unrelated hypertension and hyperlipidemia conditions. The medical record stated that Petitioner was negative for

cough, chest tightness, shortness of breath, wheezing and stridor. Pulmonary effort was normal, Petitioner was not in respiratory distress, breath sounds were normal, and he had no rales. (PX3).

11) Petitioner was never a smoker. (T.28). He testified that other than his breathing, he did not have any other health issues or concerns. (T.28). He did take medication for blood pressure and cholesterol. (T.28). Petitioner has not had any surgeries. (T.28-29).

Deposition of Dr. Suhail Istanbouly – July 20, 2020 (PX1)

12) Petitioner was referred to Dr. Istanbouly who evaluated Petitioner on June 18, 2018 for possible CWP. Dr. Istanbouly prepared a report of his evaluation which also included the results of the pulmonary function testing (PFT) performed on that same date. (T.32; PX1, Dep. Ex. 2). Dr. Istanbouly is a board-certified physician in internal medicine, pulmonary medicine, critical care medicine and sleep medicine. (PX1, pg. 5).

13) Dr. Istanbouly explained how CWP developed and stated that if the lung disease was in its early stages, then a person could still have normal PFTs, no complaints of shortness of breath, normal ABG's and a normal physical examination. (PX1, pgs. 9-10; 12).

14) Dr. Istanbouly stated that COPD, including emphysema, chronic bronchitis and asthma were typically not multifactorial in etiology, but that it could be in coal miners who smoked. (PX1, pg. 18). He confirmed that coal mine dust inhalation could result in or aggravate issues with shortness of breath, chronic cough, emphysema, chronic bronchitis and occasional asthma. (PX1, pgs. 18-19). Dr. Istanbouly had also indicated that there were other exposures in a coal mine that could damage the lungs. "Not only coal dust, but there could be silica exposure; there could be diesel fume exposure." (PX1, pgs. 14-15).

15) Dr. Istanbouly testified that when examining an individual, he would rely on the person's previous history as well as his own evaluation. (PX1, pg. 19). He also estimated that the average consensus was a minimum of 15 years of exposure for a miner to develop CWP. (PX1, pg. 20).

16) Dr. Istanbouly stated that the gold standard for diagnosing CWP was pathologic review. He agreed that an x-ray positive for CWP and sufficient exposure to coal mine dust were enough to make a diagnosis of CWP, but that a negative chest x-ray would not necessarily rule out CWP. (PX1, pg. 25).

17) Dr. Istanbouly was aware of Petitioner's job history in the coal mines and that Petitioner was not a smoker. (PX1, pgs. 26-27). He stated that Petitioner could not recall if he had ever been diagnosed with asthma, but that Petitioner reported coughing.

> [H]e mentioned that he had been coughing on [a] daily basis for years. The cough was worse during allergy season, and he noticed the correlation between the cough and postnasal drip. But apparently, his postnasal drip was persistent while working in the

> coal mine. The cough was described as mild to moderate in intensity, occasionally productive of slight clear yellowing sputum. (PX1, pgs. 27-28).

Dr. Istanbouly opined that Petitioner's coal mine exposure was an aggravating factor to his postnasal drip. (PX1, pgs. 28-29).

18) Dr. Istanbouly stated that Petitioner did not report complaints of exertional dyspnea. "[H]e was able to, he walks almost on [a] daily basis with his wife for two to three miles." (PX1, pg. 28).

19) Dr. Istanbouly testified with respect to Petitioner's June 18, 2018 PFT results:

> So per ATS guidelines, it was within normal range. FEV-1 3.29 liters, 96 percent predicted. FVC 4.57 liters, 101 percent predicted. The ratio of FEV-1 to FVC at 72 percent. So I did comment on this, because per AMA 6th Edition Guidelines for Respiratory Impairment, they consider ratio of FEV-1 to FVC less than 75 percent abnormal. (PX1, pg. 29).

20) Prior to Petitioner's evaluation by Dr. Istanbouly, Petitioner had completed a chest x-ray on August 12, 2017 which was interpreted by Dr. Henry Smith, D.O. Dr. Smith's report stated that he is a board-certified radiologist and NIOSH certified B-reader, and that he had noted evidence of simple CWP with small opacities, primary p, secondary s, mid to lower zones involved bilaterally, of a profusion 1/0. (PX2). The parties did not take the evidence deposition of Dr. Smith.

21) Dr. Istanbouly confirmed that he was neither an A nor B-reader but had reviewed the August 12, 2017 chest x-ray as well. He noted mild bilateral interstitial changes more prominent in the mid to lower zones. (PX1, pg. 29; 44; 46). He added: "[I]n the literature, they claim it is more prominent in the upper zones, but in reality in real life and based on hundreds of cases I've seen, I see it all over the lung zones. I don't see any preference in the upper lobe." (PX1, pg. 30).

22) Dr. Istanbouly further believed that inhalation of coal mine dust could result in reduced diffusion capacity. (PX1, pg. 30). He additionally opined that if Petitioner had scarring of the lungs due to having pneumonia and associated sepsis earlier in life, then those conditions could have also contributed to or reduced diffusing capacity. (PX1, pg. 31).

23) Dr. Istanbouly considered the hypothetical question that Petitioner had completed a chest x-ray for treatment purposes on July 7, 2014 and that the findings revealed accentuation perihilar lung markings. (PX1, pg. 31). Dr. Istanbouly testified that "increased accentuation, increased markings, increased prominence, in general, it's a non-specific finding by itself." (PX1, pg. 31). Dr. Istanbouly explained that perihilar lung markings could be related to CWP or chronic bronchitis if it was associated with lung scarring or lymph nodes, "[b]ut generally speaking again, in any questionable finding described like

this on the chest x-ray, if we need to investigate further, chest CT scan is the way to go." (PX1, pgs. 31-32).

24) Dr. Istanbouly diagnosed Petitioner with simple CWP and chronic bronchitis as a result of long-term coal dust inhalation. (PX1, pg. 32).

25) During cross-examination, Dr. Istanbouly confirmed that Petitioner related no past history of respiratory disease but did inform him of cough and postnasal drip especially in the allergy season. (PX1, pg. 37). Dr. Istanbouly indicated that Petitioner did not report any problems with completing his job duties in the mine. (PX1, pg. 38). He further testified, "He denied that he quit his job due to respiratory problem. So I don't know exactly did he have mild problem. But he did not quit his job because of respiratory problem." (PX1, pg. 38).

26) Dr. Istanbouly acknowledged that he did not review Petitioner's treatment records, but he had examined Petitioner and noted that Petitioner never took medication for breathing issues, his oxygen saturation was at 98 percent, there were no signs of respiratory disease and Petitioner's spirometry test was normal. (PX1, pg. 39).

Deposition of Dr. Cristopher Meyer – June 7, 2019 (RX1)

27) Dr. Meyer is a radiologist and a certified B-reader who had reviewed Petitioner's August 12, 2017 chest x-ray and prepared a report with his findings on February 7, 2019. (RX1, pg. 3; Dep. Ex. B). Dr. Meyer testified that B-readers follow a specific way to evaluate a chest x-ray for the presence or absence of occupational lung disease. (RX1, pg. 22).

28) Dr. Meyer stated that CWP is typically found in the upper zone of the lungs. He explained that B-readers had to go through an involved classification system depending on the size and appearance of opacities, the location of the opacities, and the extent of profusion. (RX1, pgs. 22-23). Dr. Meyer explained that small round opacities are categorized from "p," the smallest, to "r" the largest. For irregular opacities, "s" is the smallest and "u" is the largest. (RX1, pg. 26).

29) Dr. Meyer further emphasized the importance of the quality of the film because underexposure or overexposure could affect the number of opacities seen in the lungs. (RX1, pgs. 26-27). "Specifically occupational lung diseases are described by specific opacity types. And so silicosis and coal mine workers' pneumoconiosis are characteristically described by small round opacities; whereas, diseases that cause pulmonary fibrosis, like asbestosis, would be described by small linear or small irregular opacities." (RX1, pg. 28).

30) With respect to Petitioner's chest x-ray dated August 12, 2017, Dr. Meyer determined that it was of diagnostic quality – a Quality 2 due to under-inflation. "It causes crowding of the vascular markings of the bases, so it can simulate small linear opacities." (RX1, pgs. 40-41). Dr. Meyer's interpretation was that Petitioner's lungs were clear. "There were no small or large opacities. And my impression was no radiographic findings of coal workers'

pneumoconiosis, clear lungs." (RX1, pg. 41). Dr. Meyer disagreed with Dr. Smith's findings because he believed that the "s" opacities could be simulated by under-inflation. (RX1, pg. 41).

31) Dr. Meyer agreed that pathologic review of the tissue itself was the gold standard when trying to determine the existence of lung disease. (RX1, pgs. 46-47).

32) Dr. Meyer also agreed that some change in lung function at the site of tissue reaction may not be measurable and there may be more toxicity to the lung tissue if the individual was exposed to mixed dust instead of pure coal dust. (RX1, pgs. 55-56).

33) Dr. Meyer stated that, as a radiologist, he would pass on any questions related to PFTs as they were more in the purview of occupational lung physicians or pulmonologists. (RX1, pg. 57).

34) Dr. Meyer agreed that CWP at the level of one-over-zero, simple CWP, may take 10 years or more to develop. (RX1, pg. 65). He stated that this very slow onset was a characteristic of CWP. Dr. Meyer also agreed that a miner would not know he had CWP and would not complain to a physician until he obtained a B-reading. (RX1, pg. 65).

35) Dr. Meyer conceded that there was no NIOSH or B-reader document that stated that CWP must begin in the upper lung zones and cannot occur in the middle or lower zones without being in the upper zones. (RX1, pg. 85).

36) Dr. Meyer agreed that if a chest x-ray was positive and the worker had a sufficient history to cause CWP, then that would warrant a finding of CWP. (RX1, pg. 88).

Deposition of Dr. James Lockey – August 31, 2020 (RX2)

37) Dr. Lockey is board-certified in internal medicine, pulmonary medicine, and occupational medicine and he is also a certified B-reader. (RX2, pg. 4). Dr. Lockey had reviewed Petitioner's medical records from Dr. Muniz and Herrin Hospital, including Petitioner's prior records, and the February 18, 2019 PFT results from Stat Care. He also reviewed the reports by Dr. Meyer, Dr. Istanbouly and Dr. Smith. (RX2, pgs. 13-14). Dr. Lockey's report, dated May 7, 2020, was Deposition Exhibit B. (RX2, Dep. Ex. B).

38) Dr. Lockey testified that a cough was not considered an objective determinant of pulmonary impairment. (RX2, pg. 14). He further testified that the American Thoracic Society defined chronic bronchitis as "a daily productive cough at least of three or four days' duration, for three consecutive months for two consecutive years." (RX2, pg. 14). Dr. Lockey did not see any indication in the medical records that Petitioner had been diagnosed with chronic bronchitis. (RX2, pg. 15). He stated that allergic rhinitis was nasal congestion and sinus congestion due to an allergic response to environmental allergens. (RX2, pg. 15). Dr. Lockey explained that this condition was fairly common in the general public and that he did not see evidence in the records that Petitioner suffered a permanent aggravation of this condition due to working in the mines. (RX2, pg. 15; 44-45).

39) Dr. Lockey disagreed with Dr. Istanbouly's assessment that a ratio less than 75 percent was abnormal. "The Guides indicate it has to be below the lower limit of normal and/or below 75 percent of the predicted value." (RX2, pg. 16). He noted that the FEV1/FVC percent predicted was 94 percent on Petitioner's June 18, 2018 spirometry test which was above the 75 percent threshold for predicted and placed Petitioner in Class 0. (RX2, pgs. 15-16).

40) Dr. Lockey also testified with respect to the August 12, 2017 chest x-ray and found it was of diagnostic film quality grade 1. "I felt the film was normal. There was no indication of any changes consistent with coal workers' pneumoconiosis, profusion category 0/0." (RX2, pg. 17). He explained that for a finding of CWP you needed a profusion category of 1/0 or greater, "usually reflected by round opacities initially in the upper left lung field." (RX2, pg. 17; 49). Dr. Lockey testified: "0/1 raises the possibility of early findings consistent with pneumoconiosis but clinically the film is considered negative. 1/0 indicates that the early possibility of pneumoconiosis are most likely - - more likely present than not, and it would be considered a positive film." (RX2, pg. 18).

41) Dr. Lockey admitted that determining profusion at low levels was somewhat difficult. "There's significant inter-reader variability. There can also be intra-reader variability at those low profusion changes." (RX2, pgs. 18-19).

42) Dr. Lockey also reviewed CT scans from February 9, 2015 and February 10, 2015. "[T]here were no changes on either of these CT scans consistent with pneumoconiosis." (RX2, pgs. 19-20). He testified that the February 9, 2015 CT scan of the chest showed changes consistent with interstitial pneumonitis that subsequently resolved. Dr. Lockey indicated that this was an inflammatory process similar to pneumonia. (RX2, pg. 20). The February 10, 2015 CT scan of the abdomen and pelvis was done as a follow-up and demonstrated that the inflammatory process had cleared. (RX2, pg. 20). Dr. Lockey found no evidence of emphysema in the scans. (RX2, pg. 20).

43) Dr. Lockey stated that pneumonia or an inflammatory process could result in scarring of the lung depending on the severity, type of pneumonia and treatment modalities. (RX2, pgs. 20-21). He believed that Petitioner's reduced diffusion capacity was likely related to that inflammatory process.

> That was the only thing I could see in the medical records that could account for his mild decrease in his diffusion capacity. I didn't see any evidence that the radiologist felt there was centrilobular emphysema, so the most likely cause in this case was potential residual scarring from his pneumonia. He did have sepsis, apparently during pneumonia. That would indicate a rather severe inflammatory process during that time frame. (RX2, pg. 21).

44) Dr. Lockey had reviewed and testified with respect to Respondent's Exhibits 3, 4 and 5. (RX2, pgs. 22-23). Respondent's Exhibit 3 were the medical records from Herrin Hospital which included some unrelated lab reports and duplicate records. There was a February 8,

2015 emergency room visit where Petitioner complained of body aches, a headache, fever, vomiting and coughing. Petitioner reported taking antibiotics for an infection in his legs a couple of weeks prior. Findings under respiratory/chest indicated that Petitioner's breath sounded normal (other times it was noted as decreased breath sounds), he was not in respiratory distress, had no rales, no rhonchi, and no wheezing. It appeared that Petitioner had some type of systemic inflammatory response syndrome or SIRS with no definite source. He was additionally diagnosed with leukopenia, fever, and pneumonitis. The medical record also stated that Petitioner had sepsis possibly due to pneumonia and possibly the source of his pulmonary etiology. Petitioner was treated with multiple antibiotics. (RX3).

45) A Discharge Summary noted Petitioner's February 8, 2015 chest x-ray and February 9, 2015 chest CT scan. The x-ray revealed a slightly increased perihilar interstitial marking since the prior study, which may be related to lower lung volumes. Mild perihilar pneumonitis could not be excluded. The CT scan indicated minimal ground glass and interstitial thickening most pronounced in the right lower lobe. "May represent mild inflammation, mucus retention versus atelectasis. Axillary and mediastinal lymph nodes, likely reactive." (RX3).

46) There was also a chest x-ray from February 22, 2008. Petitioner had reported a cough. The findings revealed no evidence of acute interstitial or airspace infiltrate. There was no pleural fluid, no pathologic pleural abnormality and there was no pneumothorax identified. The impression stated no acute cardiopulmonary abnormality. (RX3).

47) Additional medical records from Dr. Muniz comprised Respondent's Exhibit 4. Petitioner had seen Dr. Muniz on July 7, 2014 indicating that he had treated with urgent care a month ago for allergies and postnasal drainage. Petitioner reported still having a cough but that it was better. Dr. Muniz noted that Petitioner had a history of seasonal allergies. Chest x-rays were ordered. Petitioner followed-up with Dr. Muniz on August 20, 2014 for his cough and reported that his "cough totally resolved." Examination revealed that Petitioner's lungs were clear to auscultation and respiratory effort was normal. The next office visit note in this Exhibit was the February 25, 2015 visit following Petitioner's sepsis/pneumonia episode as noted above. (RX4).

48) Respondent's Exhibit 5 were the records from The Lung Centre – Stat-Care. Dr. Jeffrey Selby performed a spirometry evaluation on February 18, 2019; the results were normal with mild decrease in diffusion capacity that did not correct for alveolar volume. (RX5). Dr. Lockey compared Petitioner's June 18, 2018 PFT with the February 18, 2019 PFT and stated that "the FEV1, FVC, and FEV1/FVC ratio were within normal limits. Diffusion studies from 2-18-19 were mildly reduced." (RX2, pg. 23). He opined:

> Mr. McLain does not demonstrate any objective findings consistent with coal workers' pneumoconiosis or evidence of pulmonary impairment related to past coal dust exposure. This is based on the normal FEV1, FVC and FEV1/FVC ratio and the lack of findings on the chest films and the chest CT scan report consistent with coal

> workers' pneumoconiosis. The mild decrease in the diffusion results if reproducible and persistent most likely reflects residual interstitial changes from his previous 2015 community acquired pneumonia and associated sepsis. (RX2, pg. 23).

49) During cross-examination, Dr. Lockey explained that a hacking cough was most commonly associated with acute bronchitis, either a viral infection, asthma, or pneumonia. "So those types of acute onset of symptoms usually represent inflammatory response from a viral infectious agent. So hacking cough is one of the presenting symptoms that is nonspecific in itself." (RX2, pgs. 26-27).

50) Dr. Lockey stated that the respiratory areas with mucosal lining could be aggravated by irritating fumes in the mine such as diesel exhaust, silica, roof bolting glue, and not so much from coal dust exposure itself. (RX2, pgs. 28-29). Dr. Lockey agreed that pneumonitis was inflammation of the lungs that could result in the accumulation of mucous or phlegm within the lungs. "If it's in the lung itself, it's usually inflammatory cells and interstitial edema that can result in pneumonia . . ." (RX2, pg. 30).

51) Dr. Lockey further explained the term "ground-glass opacities" indicated on the February 9, 2015 CT scan. "[U]sually I would say ground-glass opacities and interstitial thickening. That's a common phenomenon when you see an interstitial change consistent with pneumonitis or pneumonia." (RX2, pg. 31). Dr. Lockey testified that ground-glass opacities would not be seen with silica or coal dust exposure unless it was acute silicosis which was a rare condition. (RX2, pg. 31). You would also not see this with emphysema, chronic bronchitis, or asthma. (RX2, pg. 31). Additionally:

> Interstitial thickening is nondescript. It can be localized, it can be diffuse, it can be peripheral, it can be central. There's different manifestations of it. Interstitial thickening is a nondescript finding that can be due to various types of pulmonary diseases. If it's localized, it may just reflect previous scarring from a pneumonia. (RX2, pgs. 31-32).

52) Dr. Lockey stated that if it was more diffusely spread, then you would consider occupational causes. "[Y]ou start to think about autoimmune causes, hypersensitivity causes. Acute causes such as pneumonia can cause interstitial thickening if it's diffuse. So there are various causes. It depends on the clinical presentation." (RX2, pg. 32).

53) Dr. Lockey was not aware whether interstitial thickening could be a precursor to the formation of opacities. "It's not something you would find on chest x-ray or CT scan. And I'm not even aware, at pathology, you can start to see interstitial changes around the respiratory bronchiole. But most likely, they would not be manifested on a chest x-ray or CT scan initially." (RX2, pgs. 32-33).

54) During further cross-examination, Petitioner's attorney reviewed and compared the values found in the two PFTS on June 18, 2018 and February 18, 2019 with Dr. Lockey. Dr.

Lockey was not concerned over the 10 percent decrease in the eight-month period. "I wouldn't make that determination on two tests. In our epidemiology studies, we test people over a 10 to 15 year period of time, and if we see an increased loss over that period of time, then we get concerned about it." (RX2, pg. 36).

55) Dr. Lockey confirmed that he performed a records review and did not examine Petitioner. (RX2, pg. 38).

56) Dr. Lockey agreed that a coal miner could have a loss or reduction of lung function but still be within the range of normal when that individual leaves the mine. (RX2, pg. 55). He testified: "[U]nder most circumstances, you can remove a person from exposure, and it's not progressive unless you develop complicated pneumoconiosis. But if you're in a situation where the mine has a high silica content within the dust, then it definitely can be progressive even after removal from exposure." (RX2, pg. 19; 55).

57) Dr. Lockey agreed that if a person is diagnosed with CWP 10 years after leaving the mine, the odds are that person had CWP at the time he left the mine. (RX2, pgs. 56-57).

58) Dr. Lockey testified that a person could have Category 1 simple CWP and have a normal spirometry, normal pulmonary function, normal physical exam of the chest and even no complaints. (RX2, pgs. 58-59). A B-reading would help determine the CWP diagnosis. (RX2, pg. 59).

59) Dr. Lockey also agreed that the gold standard for determining the existence of CWP is pathologic review or an autopsy. (RX2, pg. 79). "[T]he coal macule, you're not going to really see the coal macule on a chest radiograph. It's the nodularity that you see on the chest radiographic. And that usually means a step up in relationship to the pathological findings." (RX2, pg. 80). Dr. Lockey further stated, "[Y]ou can have pathological findings of coal macules that aren't evidence[d] on a CT scan or chest x-ray." (RX2, pg. 80). With respect to Petitioner's B-reading: "It would not rule out that he wouldn't have pathological findings of CWP. But if he does have pathological findings of CWP, he doesn't have any impairment related to that." (RX2, pg. 81).

The Arbitrator determined that Petitioner had been exposed to an occupational disease that arose out of and in the course of his employment with Respondent. The Arbitrator noted that Petitioner worked 34 years underground as a coal miner, and during his career he was exposed to coal dust, silica dust, roof bolting glue fumes and diesel fumes. Petitioner never smoked in his lifetime and the Arbitrator considered him a credible witness. The Arbitrator also found the opinions of Dr. Istanbouly more persuasive than those of Dr. Lockey. By its Brief, Respondent conceded that Petitioner had sufficient history of coal dust exposure to cause pneumoconiosis but argued that Petitioner simply did not prove that he had CWP. Respondent, in line with Drs. Istanbouly's, Meyer's and Lockey's testimonies, stated that the gold standard for diagnosing CWP was pathologic review. Since there was no pathology admitted into evidence, interpretation, specifically a B-read, of a chest x-ray was key.

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.

Petitioner testified that he began noticing breathing problems toward the end while performing the mine examiner's job. After Petitioner stopped working for Respondent, he stated that his breathing problems gradually worsened. By his Brief, Petitioner alleged that he suffered from CWP, chronic bronchitis, COPD and "an impaired diffusion capacity (DLCO) each of which was caused at least in part and/or aggravated by his exposure as a coal miner." Petitioner claimed he also had allergic rhinitis and postnasal drip that had been aggravated by his coal mining exposures.

The evidence, however, demonstrated that after Petitioner stopped working in the mines on November 2, 2015, he did not report nor have any complaints, symptoms or treatment related to lung health until he saw Dr. Muniz on February 17, 2017 with complaints of an ongoing cough that started a month prior. Dr. Muniz believed Petitioner's condition was due to postnasal drainage. The February 17, 2017 chest x-ray indicated no significant changes from the prior 2015 chest x-ray – both of which noted the same mild accentuation of the perihilar lung markings. There was a July 7, 2014 chest x-ray that also revealed mild accentuation of perihilar lung markings, but otherwise unremarkable. Dr. Istanbouly testified that "increased accentuation, increased markings, increased prominence, in general, it's a non-specific finding by itself." (PX1, pg. 31). In discussing the 2014 x-ray, Dr. Istanbouly explained that perihilar lung markings could be related to CWP or chronic bronchitis if it was associated with lung scarring or lymph nodes, "[b]ut generally speaking again, in any questionable finding described like this on the chest x-ray, if we need to investigate further, chest CT scan is the way to go." (PX1, pgs. 31-32).

Following Petitioner's February 8, 2015 emergency room visit for his pneumonia and sepsis conditions, and which prompted the order for the February 8, 2015 chest x-ray, CT scans were performed on February 9 and February 10, 2015. Dr. Lockey specifically commented on these CT scans: "[T]here were no changes on either of these CT scans consistent with pneumoconiosis." (RX2, pgs. 19-20). He testified that the February 9, 2015 CT scan of the chest showed changes consistent with interstitial pneumonitis that subsequently resolved. Dr. Lockey indicated that this was an inflammatory process similar to pneumonia. The February 10, 2015 CT scan of the abdomen and pelvis was done as a follow-up and demonstrated that the inflammatory process had cleared.

Petitioner also completed two PFTs and the results were within normal range. Dr. Istanbouly performed the first PFT on June 18, 2018 and not only determined that it was normal, but that Petitioner's oxygen saturation was at 98 percent and physical examination of the chest revealed no signs of respiratory disease. The second PFT was completed on February 18, 2019 and interpreted as a normal spirometry but with a mild decrease in diffusion capacity.

Dr. Lockey testified that the mild decrease in the diffusion results if reproducible and persistent most likely reflected residual interstitial changes from his previous 2015 pneumonia and associated sepsis – conditions which Dr. Lockey considered to be a severely inflammatory process. Dr. Istanbouly opined that inhalation of coal mine dust could result in reduced diffusion capacity, but he also believed that if Petitioner had scarring of the lungs due to having pneumonia and associated sepsis earlier in life, then those conditions could have contributed to or reduced diffusing capacity.

The Commission finds that all three physicians testified similarly with respect to general questions posed by the attorneys. They agreed that a chest x-ray positive for CWP and sufficient exposure to coal mine dust were enough to make a diagnosis of CWP, and that a negative chest x-ray would not necessarily rule out that the miner may have pneumoconiosis pathologically. Notwithstanding, there was no pathological evidence of CWP in the record and Dr. Lockey testified that even if Petitioner had pathological findings of CWP, "he doesn't have any [clinically significant impairment] related to that." (RX2, pg. 81). This is supported by the medical evidence. All physicians agreed that if lung disease was in its early stages, a person could have normal test results, no complaints, and a normal physical examination. However, both Drs. Meyer and Lockey indicated that a B-reading would help determine a CWP diagnosis.

Dr. Smith's B-read of the August 12, 2017 chest x-ray was the only B-read that indicated CWP. Respondent presented the evidence depositions of its certified B-readers, Drs. Meyer and Lockey, who testified that Petitioner's August 12, 2017 chest x-ray was normal and that there was no evidence of CWP. Dr. Smith did not provide any testimony or explanation with respect to his findings. The Commission finds that the testimony, explanations, and findings by Respondent's B-readers were more thorough and persuasive than the stand-alone report of Petitioner's B-reader, Dr. Smith.

Dr. Istanbouly had also noted that Petitioner reported a correlation between his cough and postnasal drip that was persistent while working in the coal mine and worse during allergy season. Dr. Istanbouly therefore believed that Petitioner's coal mine exposure was an aggravating factor to his postnasal drip. Dr. Lockey testified that Petitioner's cough was indeed related to his postnasal drainage and allergic rhinitis but saw no work-related or permanent aggravation of that condition. He acknowledged, as the Arbitrator noted, that in general, exposure to diesel fumes and fumes from materials that are used in the mines other than coal or silica dust could cause an exacerbation. Dr. Lockey also indicated that a cough could be multifactorial, and if so, then various insults contributing to that condition would be additive. Dr. Lockey agreed further that a person could have allergic rhinitis from any cause and have the condition aggravated by workplace exposures. Notwithstanding, Dr. Lockey testified that "the records said those [symptoms] didn't change when [Petitioner] was in the coal mine in comparison to when he was outside the coal mine." (RX2, pg. 45). Dr. Lockey found that Petitioner's allergic rhinitis condition "wasn't aggravated when he went underground. It just did not change." (RX2, pg. 47). The record supports this finding.

The Commission finds that many of Petitioner's lung issues and any abnormalities indicated on prior chest x-rays and CT scans appeared related to or immediately followed non-

occupational-related conditions, e.g., a cough without further explanation, allergies, postnasal drainage, pneumonia, and sepsis. It appeared that a few times a year, Petitioner would report symptoms of cough and related issues due to other etiology and then those conditions would resolve. The Commission finds no evidence of any chronic, continuous, or progressive lung conditions that necessitated ongoing treatment or that were connected to Petitioner's coal mining duties with Respondent. The Commission further finds the opinions of Drs. Meyer and Lockey more persuasive than Dr. Istanbouly's opinions and Dr. Smith's report – especially with respect to their B-read of the August 12, 2017 chest x-ray.

Based on the preponderance of the foregoing evidence, the Commission finds that Petitioner failed to prove that he suffers from CWP and further finds that Petitioner failed to prove that his alleged chronic bronchitis, COPD, impaired diffusion capacity, allergic rhinitis and postnasal drip conditions arose out of, or in the course of, or were related to his coal mine exposure while working for Respondent. Accordingly, the Arbitrator's PPD award of five percent (5%) loss of the person as a whole is stricken.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on August 5, 2021, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's PPD award of five percent (5%) loss of the person as a whole is hereby stricken.

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.

April 20, 2022
CAH/pm
O: 3/3/2022
052

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

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

DISSENT

I disagree with the majority's decision to reverse the Decision of the Arbitrator. The Arbitrator correctly found Petitioner was last exposed to an occupational disease (coal workers' pneumoconiosis) on November 2, 2015, which arose out of and in the course of his employment with Respondent and satisfied the requirements of Section 1(d) of the Illinois Workers' Compensation Act (the "Act"). Further, the Arbitrator correctly found that Petitioner satisfied the requirements under Section 1(e) and (f) and was disabled within two years after the last day of

his last exposure on November 2, 2015. I also agree with the Arbitrator's analysis under Section 8.1b of the Act, finding that Petitioner's coal workers' pneumoconiosis caused a five percent loss of the person-as-a-whole. Accordingly, I would affirm the Decision of the Arbitrator and clarify that Petitioner also proved by a preponderance of the evidence that Petitioner's coal mine exposures also caused chronic bronchitis.

Petitioner credibly testified that he has worked in the mines underground for a total of thirty-four years with approximately thirty of those years for Respondent. Petitioner testified he began having breathing problems at work toward the end of his career at Respondent's mine. Petitioner testified he has continued to experience breathing problems that have worsened somewhat since he was laid off from his job with Respondent on November 2, 2015. Petitioner testified he notices breathing problems while performing his current job in maintenance, primarily when he has to carry things or climb stairs. Further, he notices difficulties in being active with his grandchildren. Petitioner testified that he has never smoked.

On September 25, 2017, Dr. Smith, a NIOSH certified B-reader since 1987, reviewed the August 12, 2017 chest X-ray. Dr. Smith opined that the film was quality 1 and it showed simple coal workers' pneumoconiosis with small opacities.

On June 18, 2018, Petitioner underwent pulmonary function testing (PFT) at Dr. Istanbouly's recommendation. Dr. Istanbouly, a board-certified critical care and pulmonary medicine physician, examined Petitioner on June 18, 2018 and took a detailed history of Petitioner's employment. Dr. Istanbouly opined that Petitioner's coal mine exposures were an aggravating factor for his history of a cough and postnasal drip. Dr. Istanbouly opined that a longer period of exposure to coal mines will not only aggravate postnasal drip, but will make it worse. Dr. Istanbouly reviewed Petitioner's June 18, 2018 PFT and opined that it was within normal range. Dr. Istanbouly reviewed Petitioner's August 12, 2017 chest X-ray and opined that it showed interstitial changes, and he concurred with Dr. Smith's reading of the film. Dr. Istanbouly opined that Petitioner had simple coal workers' pneumoconiosis and chronic bronchitis, both of which were caused by long term coal dust inhalation. Thus, Dr. Istanbouly opined that Petitioner could have no further exposure to the environment of the coal mine without endangering his health. At his deposition, Dr. Istanbouly opined that the inhalation of coal mine dust and related lung disease can be a cause of reduced diffusion capacity, and reduced diffusion capacity can be multifactorial.

On February 7, 2019, Dr. Meyer, a NIOSH certified B-reader since 1999, reviewed the August 12, 2017 chest X-ray and opined it was a quality 2 film due to underinflation. Despite this finding, however, Dr. Meyer opined the film showed no radiographic findings of coal workers' pneumoconiosis.

On February 18, 2019, Petitioner underwent PFT performed by Dr. Selby. Dr. Selby interpreted the PFT as a normal spirometry with a mild decrease in diffusion capacity that did not correct for alveolar volume.

On May 7, 2020, Dr. Lockey, a board-certified internal medicine, pulmonary medicine, and occupational medicine physician and certified B-reader, performed a records review. Dr.

Lockey reviewed the August 12, 2017 chest X-ray and opined that it was a quality 1 film and demonstrated no changes consistent with coal workers' pneumoconiosis. Dr. Lockey also reviewed Petitioner's PFTs and opined that they were normal. However, Dr. Lockey acknowledged that diffusion studies from February 18, 2019 were mildly reduced and opined that the mild decrease in the diffusion results, if reproducible and persistent, most likely reflected residual interstitial changes from Petitioner's previous 2015 pneumonia and resulting sepsis. At his deposition, Dr. Lockey testified that the reason why he believed the reduction in diffusion capacity was related to an inflammatory process (previous pneumonia) was because it was "the only thing [he] could see in the medical records that could account for his mild decrease…"

Dr. Lockey concluded that Petitioner did not demonstrate any findings consistent with coal workers' pneumoconiosis or evidence of pulmonary impairment related to past coal dust exposure. Dr. Lockey based this opinion on the lack of findings on the chest X-ray as well as the normal PFTs. Dr. Lockey opined further that a cough can be multi-factorial in etiology. Dr. Lockey opined that chronic cough is one of the symptoms of chronic bronchitis. Dr. Lockey acknowledged that the medical records he reviewed did not contain detailed work histories and he would be in a better position to make opinions regarding Petitioner's pulmonary system if he had the ability to obtain his own patient history from Petitioner.

The Arbitrator found that the medical records from Dr. Muniz, Petitioner's family doctor, noted several instances of cough, chronic cough, postnasal drip, and allergies, in addition to instances of acute pneumonia.

The claimant in an occupational disease case has the burden of proving both that he or she suffers from an occupational disease and that a causal connection exists between the disease and his or her employment. *American Coal Co. v. Illinois Workers' Compensation Comm'n*, 2020 IL App (5th) 190522WC, ¶ 50; *Freeman United Coal Mining Co. v. Illinois Workers Compensation Comm'n*, 2013 IL App (5th) 120564WC, ¶ 21. Whether a claimant suffers from an occupational disease and whether there is a causal connection between the disease and the employment are questions of fact. *American Coal Co.*, 2020 IL App (5th) 190522WC, ¶ 50; *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21. It is the function of the Commission to decide questions of fact, judge the credibility of witnesses, and resolve conflicting medical evidence. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*, 2013 IL App (5th) 120564WC, ¶ 21; *see* also *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). In this case, I would find that Petitioner met his burden of proving an occupational disease claim.

Under Section 1(d) of the Act, Petitioner met his burden and proved exposure to the hazards of coal workers' pneumoconiosis and chronic bronchitis where he worked in coal mines for a total of thirty-four years (thirty being with Respondent) based on the persuasive opinions of Dr. Istanbouly and Dr. Smith who both agreed that the August 12, 2017 chest X-ray was a quality 1 film and showed simple coal workers' pneumoconiosis. Significantly, Dr. Meyer and Dr. Lockey disagreed as to the quality of the August 12, 2017 chest X-ray (Dr. Lockey opined it was a quality 1 film while Dr. Meyer opined it was a quality 2 film due to underinflation), yet both opined that it showed no pneumoconiosis. Further, as stated by the Arbitrator, Dr. Lockey's opinions are undermined by the fact that his report omitted certain medical records and Dr.

Lockey opined that he would have benefitted from taking a history from Petitioner himself. Finally, I find the reduced diffusion capacity on Petitioner's February 18, 2019 PFT to be significant in light of the fact that Petitioner never smoked and based on Dr. Istanbouly's opinion that inhalation of coal mine dust and related lung disease can be a cause of reduced diffusion capacity. Dr. Lockey's opinion that the reduced diffusion capacity was related to a 2015 pneumonia and sepsis diagnosis appears to be speculative as Dr. Lockey did not provide a credible basis for this opinion and his medical records review, on which he relied in formulating his opinions, was incomplete. Accordingly, I do not find the opinions of Dr. Lockey or Dr. Meyer persuasive. Based on the totality of the evidence, Respondent failed to rebut the presumption that Petitioner's coal workers' pneumoconiosis arose out of his employment. Further, based on totality of the evidence, Petitioner's conditions of coal workers' pneumoconiosis and chronic bronchitis are causally connected to his exposure.

With respect to disablement, Section 1(f) provides in relevant part that "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f) (West 2008). Section 1(e) of the Act provides two ways to establish disablement. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 25; *Forsythe v. Industrial Comm'n*, 263 Ill. App. 3d 463, 470 (1994). A claimant can establish disablement by showing "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e) (West 2008). Alternatively, section 1(e) defines disablement as "the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment." 820 ILCS 310/1(e) (West 2008). Under Sections 1(e) and 1(f) of the Act, I agree that Petitioner established timely disablement based on: (1) his stated impairment in function, which is corroborated by the findings on the August 12, 2017 chest X-ray as interpreted by Dr. Smith and Dr. Istanbouly; and (2) his inability to return to coal mining without further endangering his health.

Notwithstanding my agreement with the Decision of the Arbitrator in the above respects, I would clarify that Petitioner further proved by a preponderance of the evidence, that he suffered from both coal workers' pneumoconiosis and chronic bronchitis based on the persuasive opinions of Dr. Istanbouly and Dr. Smith and the totality of the evidence in this case.

For the above reasons, I respectfully dissent.

/s/ *Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC026821
Case Name	MCLAIN, JAMES v. THE AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Kenneth Werts

DATE FILED: 8/5/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 3, 2021 0.05%

/s/ Linda Cantrell, Arbitrator

Signature

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

JAMES MCLAIN
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **17** WC **026821**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 17, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/02/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$92,701.44**; the average weekly wage was $**1,782.72**

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

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

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $**755.22 (Max rate)**/week for a period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused a **5% loss of Petitioner's body as a whole.**

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

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

AUGUST 5, 2021

Arbitrator Linda J. Cantrell

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES MCLAIN,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 17-WC-026821
	)	
THE AMERICAN COAL COMPANY,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on May 17, 2021 on all issues. An Application for Adjustment of Claim was filed on September 13, 2017 wherein Petitioner alleges he sustained an occupational disease of his lungs, heart, pulmonary system and respiratory tracts as the result of inhaling coal mine dust, including, but not limited to, coal dust, rock dust, fumes, and vapors for a period in excess of 34 years. The Application alleged a date of last exposure of November 2, 2015. The issues in dispute are accident, causal connection, the nature and extent of Petitioner's injuries, and Sections 1(d)-(f) of the Occupational Diseases Act. All other issues have been stipulated.

TESTIMONY

Petitioner is 61 years old, married, and has no dependent children. He graduated high school and has worked 34 years in the coal mining industry all of which were underground. During the course of his mining career Petitioner was exposed to coal dust, silica dust, roof bolting glue fumes, and diesel fumes.

Petitioner last worked in the coal mine on November 2, 2015 for Respondent at the Galatia mine. He was laid off on that date. He was 56 years of age with a job classification of mine examiner. On that day he was exposed to and breathed coal mine dust. Petitioner obtained post-mining employment on 3/3/16 with the Franklin County Housing Authority. He performs maintenance duties and works 40 hours per week making approximately $26.00 per hour.

Petitioner first began working in the coal mines in 1979 for Old Ben Coal in West Frankfort, Illinois. He was hired as a laborer and performed construction, set timbers to support the mine roof, and shoveled coal off of the belts. Petitioner testified that his job was very dusty. Petitioner's next job was on a loading unit where they produced coal at the face of the mine. Petitioner ran a buggy or shuttle car. This machine takes the coal from the face of the mine to the

belts to be taken out of the mine. Petitioner next worked in the belt maintenance department where he installed and took out belts. He also was responsible for maintaining and repairing the belts. Petitioner did belt maintenance for approximately a year and a half. He next moved to the long wall. The long wall is a shear that goes along the face of the mine, cutting the coal and dropping it to the ground. Petitioner described the conditions as very dusty. Petitioner left Old Ben in 1983 and worked construction for approximately two years before hiring on at Kerr McGee in 1985, which later became American Coal. He was a laborer in construction. He then went back in production at the face running a buggy hauling the coal from the miner to the belt. After approximately a year he went back to working the long wall. He worked at the long wall for a few years and then went back to belt maintenance. He did belt maintenance for a few years and then went to pumping. He described these pumps as very large sump pumps. He was a pumper for approximately eight years and then became a mine examiner. His duties included inspecting the roof, checking for gas, methane, explosive gas, oxygen, and any potential safety hazards. As a mine examiner, Petitioner traversed the entire area of the mine which he described as a physically demanding job.

Petitioner first noticed breathing problems towards the end of his mining career. He felt more winded and had a little more trouble breathing. Petitioner testified that since he left the mine his breathing has gradually worsened. His breathing problems effect his daily life. He described having difficulty on the job when climbing stairs or when carrying heavy objects. He described not being able to handle his grandkids as much as he would like. Petitioner's family doctor is Dr. Javier Muniz in Herrin. Petitioner is a never smoker. He takes medication for blood pressure and cholesterol.

On cross-examination, Petitioner testified he would have continued working for Respondent had he not been laid off. He underwent periodic NIOSH screening for black lung involving chest x-rays every five years.

MEDICAL HISTORY

Dr. Suhail Istanbouly is board-certified in internal medicine, pulmonary medicine, critical care medicine, and sleep medicine. Dr. Istanbouly testified that coal worker's pneumoconiosis requires a tissue reaction in addition to the deposition of coal mine dust in the lungs, commonly called scarring or fibrosis. That macule of CWP trapped in coal mine dust surrounded by that fibrosis or scarring is with a halo of focal emphysema. The macule cannot perform the same function as normal healthy lung tissue. CWP at the site of each abnormality causes impairment of the function of the lung at that site, whether it is measured by pulmonary function testing or not. Dr. Istanbouly testified that in its early stages, it is possible to have injury or disease to the lung and still have normal pulmonary function tests. It is possible for a person to begin their mining career at the top of the range of normal, leave at the bottom range of normal and have a significant loss of lung function yet at both times be within the range of normal. A person can have CWP despite having no complaints of shortness of breath, normal PFTs, normal ABGs, and normal physical examination of the chest. There is no cure for CWP. If a miner has CWP that is progressing, there is not really any medicine or medical treatment you can give to stop or reverse that progression. Coal mine dust inhalation can result in shortness of breath, chronic cough, emphysema, chronic bronchitis, and occupational asthma. If a person has COPD, emphysema,

chronic bronchitis, asthma, or CWP, the best advice is to avoid the agents that can cause and aggravate them. If you read an x-ray for being positive for CWP and you know the miner has had sufficient exposure to coal mine dust to cause that disease, those two things combined are sufficient to make a diagnosis of CWP. If on the other hand, you read the chest x-ray as being negative, that could never rule out the existence of CWP.

Dr. Istanbouly testified regarding Petitioner's history of cough. He mentioned that he had been coughing on a daily basis for years, it was worse during allergy season, and he noticed the correlation between the cough and postnasal drip. But apparently, his postnasal drip was persistent while working the coal mine. The cough was described as mild to moderate in intensity, occasionally productive of light yellowish sputum. Dr. Istanbouly testified that the coal mine exposures were definitely an aggravating factor of Petitioner's postnasal drip. If you have an aggravating factor of coal mine exposure for postnasal drip and you continue it, a longer period of exposure not just aggravates it while you are at the mine but make it worse. Dr. Istanbouly testified that Petitioner's PFTs were within a normal range. FEV1 3.29 liters 96% predicted, FVC 4.57 liters 101% predicted. The ratio of FEV1 to FVC at 72%. Dr. Istanbouly testified that per AMA 6th Edition Guidelines for Respiratory Impairment, it would consider a ratio of FEV1 to FVC less than 75% abnormal. Dr. Istanbouly testified to a reasonable degree of medical certainty that Petitioner has CWP and chronic bronchitis, both of which were caused by long term coal dust inhalation. In light of both of these diagnoses, Dr. Istanbouly testified that Petitioner could have no further exposure to the environment of the coal mine without endangering his health.

At Petitioner's attorney's request, b-reader, Dr. Henry K. Smith reviewed a grade 1 chest x-ray dated August 12, 2017. Dr. Smith found interstitial fibrosis of classification p/s, bilateral mid to lower zones involved, of a profusion 1/0. There are no chest wall plaques, calcifications, or large opacities. There are mild accentuated subpleural fat deposits laterally in the bilateral mid to lower lungs. Heart size is normal. There is mild lower dorsal spondylosis. Dr. Smith's impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, mid to lower zones involved bilaterally, of a profusion 1/0.

Medical records of Dr. Javier Muniz were admitted into evidence. On an office note dated 7/7/14 the symptoms began one month ago. The symptoms are reported as being moderate and are a new onset. Was evaluated a month ago and treated in an urgent care for allergies and postnasal drainage. He was treated with three types of medications: cough syrup, steroid, and Amoxil. Has a history of seasonal allergies. He was positive for cough, the quality is hacking. On an office note dated 8/20/14 under history of present illness: one month f/u cough. He states the symptoms have resolved cough totally resolved. Doing significantly better. On an office note dated 2/25/15 under history of present illness: sepsis/pneumonia f/u. Symptoms are reported as being moderate. He states that symptoms are acute and have resolved. Recent hospitalization and treated for possible pneumonia. Had leukopenia as well. On an office note dated 2/17/17 under history of present illness: cough. Pertinent negatives include: dyspnea, dyspnea on exertion, hemoptysis and hoarseness. The patient does not have a history of allergies or asthma. Additional information: complains of ongoing cough. Some phlegm. Intake comments: started with cough one month ago. Was dry, now bringing up clear sputum. Some sore throat and headache yesterday, no known fever, felt chest congestion two days. Under problems list: chronic cough.

Onset date 2/17/17. On an office note date 2/5/18 under problem list: chronic cough. Onset date 2/17/17. On and office note dated 7/30/18 under problem list: chronic cough, onset date 2/17/17. On an office note dated 1/28/19 under problem description, chronic cough, onset date 2/17/17. On an office note dated 7/22/19 under problem description: chronic cough, onset date 2/17/17. On an office note dated 3/11/20 under subjective, James presents today with a cough and congestion 48 hours ago. His wife was sick on Friday and he started off with it this past Monday. Under that same office note, under review of systems, respiratory: positive for cough, negative for chest tightness, shortness of breath, wheezing and stridor. Diagnosis and all other orders for visit: acute bronchitis, unspecified organism. On an office note dated 3/24/20, under subjective: complains of ongoing cough two weeks ago. Coughing continues with congestion that has subsided but coughing has not gone away. Feels like annually gets this. Under review of systems: respiratory: positive for cough (non-productive. Hemoptysis). Under instructions: James was seen today for continual cough. Under diagnosis and all orders for this visit: acute bronchitis, unspecified organism. Seasonal rhinitis due to pollen. On a chest x-ray dated 2/17/17 under reason for study: cough. Impression: mild prominence of the perihilar lung markings is not significantly changed from the prior exam and may represent a perihilar pneumonitis. Otherwise no acute cardio pulmonary findings. On a chest x-ray dated 7/7/14, history: cough. Under impression: mild accentuation of the perihilar lung markings. Otherwise unremarkable findings.

At Respondent's attorney's request, Dr. Cristopher Meyer reviewed a pa chest radiograph dated August 12, 2017 from Harrisburg Medical Center. It was a quality 2 diagnostic quality due to underinflation. His interpretation was that the lungs were clear with no small or large opacities. His impression was no radiographic findings of CWP. On cross-examination, Dr. Meyer stated that it is true that when you want to determine the existence of lung disease, the gold standard is pathologic review of the lung tissue itself rather than radiological. When a miner has mixed dust exposure as opposed to just coal dust, it is fair to say that there can be more toxicity to the lung tissue. For instance, if there is more silica in the lung. The abnormality of CWP is a permanent abnormality. Dr. Meyer testified that to his knowledge there is no medicine or anything modern medical science can do to stop or reverse the progression of CWP once it begins the progression. Removing a worker from the exposure is the best response. Dr. Meyer agreed that CWP can be considered a chronic progressive disease in some miners and can progress even after the miner leaves the coal mine. If a miner has CWP at any time in their life, inasmuch as the only thing that causes CWP is coal mining exposure, it would be true that they probably had that CWP at some level when they left the coal mine. Dr. Meyer testified that he would expect that the CWP would appear first radiographically or pathologically and then later as it became more significant, it would begin to manifest itself in pulmonary function abnormalities or clinical abnormalities. When a coal worker has CWP that progresses, the rate of that progression would vary from miner to miner. Silica generally comes from the rock that is associated or intermixed with the coal that is being mined. Certain occupations in the mine such as roof bolting, drilling or shooting where there may be more rock involvement, would tend to have greater silica exposure. It is possible that CWP could develop at any point in a miner's career, including in the last month or so; in fact, even show up radiographically a month or so after he left the mine.

At Respondent's attorney's request, Dr. James Lockey performed a records review. Dr. Lockey testified that based on currently available information, Petitioner does not demonstrate

any objective findings consistent with CWP or evidence of pulmonary impairment related to past coal dust exposure. This is based on the normal FEV1, FVC, and FEV1/FVC ratio and the lack of findings on the chest films and the chest CT report consistent with CWP. The mild decrease in the diffusion results if reproducible and persistent most likely reflects residual interstitial changes from his previous 2015 community acquired pneumonia and associated sepsis. A capacity of 66%, that can be below the lower limit of normal. Dr. Lockey testified that if you have identical measured results on a person on two different tests, you have NHANES on one and KNUDSON on the second one. While the obtained numbers could be the same, the predicted values could be different. Dr. Lockey testified in general a cough can be multifactorial in etiology. When the cough is multifactorial, the various insults contributing to it would be additive. Dr. Lockey testified he agrees with the statements from the AMA Guides 6th Edition Chapter 5. That is, the goals of the impairment assessment of the pulmonary system should be to determine if the person has pulmonary impairment, quantified in severity and assess its impact on the ability to perform activities of daily living. Dr. Lockey also agreed with the AMA Guides that a detailed clinical evaluation of the pulmonary system should begin with a comprehensive history and inquiry of the specific system severity, duration, and manor of onset guide, the initial evaluation, and a detailed work history is of critical importance. Dr. Lockey agreed that the medical records he reviewed do not contain a detailed work history. He admitted he would have been in a better position to make opinions regarding Petitioner's pulmonary system, a possible existence of chronic bronchitis or other diseases, particularly those that involve cough, if he would have had the ability to take his own patient history from Petitioner.

Dr. Lockey stated he generally agreed with the statement from the thoracic society, that says if a person is diagnosed with CWP there is no safe level of exposure. You can have chronic bronchitis with PFTs within the range of normal. Silica exposure can be more damaging to the lungs than pure coal dust exposure. Someone who has silicosis can have a progressive disease even removed from the exposure. Scar tissue cannot perform the function of normal healthy lung tissue. A person can have category 1 CWP and still have normal blood gases, normal physical exam of the chest, no symptoms and normal spirometry. They could have category 1 CWP and be completely asymptomatic. Inhalation of coal dust can result in emphysema, chronic bronchitis, and COPD. You can have chronic bronchitis without having obstructive defect even though it is listed as one of the COPDs. Inhalation of coal mine dust can result in shortness of breath and dyspnea on exertion. There is no treatment for CWP.

Medical records from Herrin Hospital were admitted into evidence. On an office note dated 2/8/15 cough description: non-productive, dry. On an emergency room note dated 12/6/17 under chief complaint: fever currently, cough, non-productive, other. Under associated symptoms, reports chills, reports cough, non-productive. Under respiratory reports non-productive cough, denies dyspnea on exertion, denies aortic pain. Denies shortness of breath. On a note dated 2/11/15 under images and studies: chest x-ray dated 2/8/15 shows slightly increased perihilar interstitial markings since prior study. This may be related to lower lung volumes. Do not exclude mild perihilar pneumonitis. Chest CT on 2/9/15 showed minimal ground glass and interstitial thickening most pronounced in the right lower lobe. May represent mild inflammation, mucus retention vs. atelectasis. On an office note dated 2/8/15 under past medical history: chronic cough. On a note dated 2/10/15 under respiratory: no respiratory distress,

decreased breath sounds [right base]. On an office note dated 2/9/15 under respiratory: no respiratory distress, decreased breath sounds [right base].

A spirometry report dated 2/18/19 was normal, with mild decrease in diffusion capacity that does not correct for alveolar volumes.

CONCLUSIONS OF LAW

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

Issue (F): Is Petitioner's current condition of ill-being casually related to his occupational exposure?

The Arbitrator finds that Petitioner was last exposed to an occupational disease that arose out of and in the course of his employment with Respondent. Section 1(d) of the Illinois Workers' Compensation Diseases Act states, in pertinent part:

> "A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists...If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment." 820 ILCS 310/1(d)

Petitioner worked as a coal miner for approximately 34 years, all of which were underground. He is a lifelong never smoker of cigarettes. In addition to coal dust, during his mining career, he was also exposed to silica dust, roof bolting glue fumes, and diesel fumes. The Arbitrator found Petitioner to be a credible witness.

The Arbitrator finds the opinions of Dr. Istanbouly more credible than those of Dr. Lockey. Dr. Istanbouly performed a complete black lung examination. His patient history included a detailed description of Petitioner's occupational history, work requirements, and perceived pulmonary health. Such history is required for a complete pulmonary examination by the AMA Guides, 6th Edition. Dr. Istanbouly is a highly-credentialed pulmonologist with a long history of serving miners from southern Illinois. There was nothing in the record to call his credibility into question. Dr. Lockey is also a highly-credentialed pulmonologist. His practice is in Cincinnati, Ohio, not southern Illinois, the location of Petitioner, and the coal mine locations. The Arbitrator does not take a position on the relative value of a complete records review versus

a medical examination; however, in this case, the content and use of the records review require giving greater weight to the examination.

First, the records review was incomplete and lacking credibility. The review discussed approximately 41 entries relevant to Petitioner's pulmonary health; however, the Arbitrator notes approximately 100 relevant entries in the actual records. A review which does not include over half of the relevant medial record entries cannot be accorded much weight. Closer inspection of the records review shows that it included only nine entries of relevant diagnoses, while the actual records contained 24. The review contained only 13 entries of symptoms, while the actual records contained approximately 30. This is significant, because Dr. Lockey noted that part of his opinions were based on a lack of chronic breathing problems. It would be difficult to determine whether symptoms were chronic if over half of the medical record entries of symptoms were not considered. Dr. Lockey's review listed 13 entries of relevant prescription medications, while the actual records contained approximately 32 such entries. An understanding of the number and types of prescriptions would be important to an understanding of the extent of the treatment as well as the degree of attention the treaters paid to Petitioner's breathing problems. Finally, as to causation, the records showed Petitioner to be a lifelong never smoker, and they also referred to Petitioner's work as a coal miner several times. The sum of all the omissions in Dr. Lockey's records review gives rise to a lack of credibility.

Whether Dr. Lockey was not provided with all the records or whether he failed to review all the records he was provided is irrelevant. The fact remains that his opinions were based on woefully incomplete data, and his opinions cannot be better than the data on which they were based. The Arbitrator notes that the records contained eight references to "chronic cough" and 10 references to "cough." Dr. Lockey's review listed only one reference to "cough" and four references to "chronic cough."

Dr. Lockey testified that he did not see a diagnosis of chronic bronchitis in the treatment records. But he also testified that a lack of a diagnosis in the records of a family physician does not equate to a certainty that the disease does not exist. As to the medical significance of chronic bronchitis, he testified that chronic bronchitis or chronic cough is not a normal state; it is an abnormal state of health. He testified that the symptoms of chronic bronchitis would indicate a change in the architecture or the nature of the mucosal lining, including perhaps a thickening of it that might be measured by the Reid Index at pathologic examination. Dr. Lockey testified regarding the possibility that Petitioner has allergic rhinitis which is causing his cough; however, he also testified that while coal dust would not be an aggravating factor for allergic rhinitis, exposure to diesel fumes or silica, or other materials that are used in the coal mines could cause exacerbations. Petitioner's uncontroverted testimony documents occupational exposure to silica, diesel fumes, and fumes from roof bolting glue. While Dr. Lockey testified that he believed Petitioner's cough to be due to his postnasal drainage and his allergic rhinitis, his review of the medical records noted only one entry of postnasal drainage, just two entries referring to allergies, and no entries referring to allergic rhinitis. He also weakened his opinion regarding causation of the cough. He testified that a cough can be multifactorial in its etiology, and that when it is, the various insults contributing to it would be additive. He further testified that COPD is chronic bronchitis, emphysema, or a chronic asthmatic condition.

Regarding the value of his records review, Dr. Lockey testified that he agrees with the AMA Guides that a detailed clinical evaluation of the pulmonary system should begin with a comprehensive history and inquiry of the specific symptom severity, duration, and manner of onset. He testified that these treatment records do not have such history. He testified that in order to arrive at the best medical opinion regarding Petitioner's pulmonary system, a possible existence of chronic bronchitis or other diseases, particularly those that could involve cough, he would have been in a better position to make his opinions if he had the ability to take his own patient history. "Yes, I would rely on my own history in regard to any pulmonary evaluation. I would put more reliance based on my expertise in the field."

Regarding the diagnosis of CWP, the Arbitrator finds that Dr. Lockey's lack of credibility in his records review was significant enough to carry over to his opinion as a b-reader. The Arbitrator can find no reason to grant Dr. Lockey more credibility when reading an x-ray than he earned while reading the medical records. B-reader Dr. Smith found CWP, and b-reader Dr. Meyer did not. Dr. Istanbouly found CWP on the x-ray. He is not a b-reader but based on his long experience in providing care to coal miners, his opinion is given some weight. The Arbitrator notes that the treatment records contain a chest x-ray from 2/8/15 which reported "mild prominence perihilar lung markings." A chest CT of 2/9/15 noted "minimal ground glass and interstitial thickening." A chest x-ray of 7/7/14 reported "lung volumes decreased since prior exam," and "slightly increased perihilar interstitial markings." A chest x-ray of 2/17/17, which was taken for "cough," reported "mild prominence of perihilar lung markings" not changed from the x-ray of 2/8/15. The Arbitrator does not interpret the findings of the treating radiologists regarding a diagnosis of CWP; however, the Arbitrator does note that in each of the several radiographic studies in the medical records, abnormalities of the lung were found. Dr. Lockey presented a source for the abnormalities other than CWP; however, he did not testify that the abnormalities could not be multifactorial or that if Petitioner suffers from an occupational disease, such disease could not be a causative factor in these abnormalities. Both Dr. Smith and Dr. Istanbouly did find abnormalities which they classified as being consistent with CWP. In addition, Dr. Lockey testified that he recalled the data in the studies by Vallyathan and Kuempel in which they determined that long-term coal miners will be found to have CWP at autopsy over 90% of the time. The Arbitrator finds the totality of this evidence sufficient to support the x-ray readings of Dr. Smith and Dr. Istanbouly, making them most credible.

Finally, the testing from Stat Care, which was provided by Respondent, documents Petitioner suffers from a reduced DLCO. According to the testimony, this abnormality affects the gas exchange areas of the lung, and is consistent with the diseases Petitioner has alleged. In this never-smoking coal miner, who worked underground for 34 years, and was regularly exposed to coal dust, silica dust, roof bolting glue fumes, and diesel fumes, there is ample exposure to support the opinions and testimony of Dr. Istanbouly.

Given the totality of the evidence, the Arbitrator finds Petitioner has satisfied the requirements of Section (d) of the Act and that Petitioner's coal workers' pneumoconiosis arose out of and in the course of his employment with Respondent. The Arbitrator further finds that Petitioner's condition of ill-being is causally connected to this exposure.

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

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

(i) **Level of Impairment**: Petitioner's pulmonary function testing showed an impairment in his diffusion capacity. This impairment is consistent with his occupational diseases. Dr. Lockey testified that under the AMA Guides, Petitioner's spirometry results would be in Class 0; however, the DLCO is not a spirometric measurement, and it is impaired. The Arbitrator gives some weight to this factor.

(ii) **Occupation**: Petitioner was laid off by Respondent in November 2015. He obtained subsequent employment on 3/3/16 with the Franklin County Housing Authority performing maintenance duties. He works 40 hours per week making approximately $26.00 per hour. The Arbitrator gives greater weight to this factor.

(iii) **Age**: Petitioner was 56 years old at the time of his last exposure. Petitioner continues to work on a full-time basis in a different occupation. The Arbitrator gives some weight to this factor.

(iv) **Earning Capacity**: Based on the medical evidence, Petitioner is medically precluded from further coal mine work which was the primary type of employment in Petitioner's working career. However, Petitioner testified he would have continued working in the mine for Respondent had he not been laid off. Petitioner obtained subsequent employment after being laid off by Respondent and currently works 40 hours per week making $26.00 per hour, resulting in reduced earnings of approximately $742 per week. The Arbitrator places some weight on this factor.

(v) **Disability**: As a result of his work exposure, Petitioner testified to increased respiratory difficulty with his activities of daily living. Dr. Istanbouly testified that the inhalation of coal dust that causes irritation and inflammation will ultimately form tiny scars. Dr. Istanbouly testified there is no cure for coal workers' pneumoconiosis and the condition is chronic. Petitioner received extensive treatment for pulmonary problems as displayed in the medical records. The treatment records contain 100 references pertaining to his pulmonary health. The Arbitrator places greater weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator orders Respondent to pay Petitioner the sum of $**755.22 (Max. rate)**/week for a period of **25 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused **5% loss of the body as a whole.**

Issue (O): Sections 1(d)-(f) of the Occupational Diseases Act.

Section 1(e) of the Occupational Diseases Act states, in pertinent part, "{d}isablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e). The Arbitrator finds Petitioner has satisfied the requirements of Section (e) of the Act.

Section 1(f) of the Occupational Diseases Act states, in pertinent part, "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f). Petitioner last worked a day of coal mine employment on November 2, 2015. Petitioner has not worked in the coal mines and has not had any other exposure to coal mine dust since that date. The Arbitrator finds that Petitioner has proven his diseases and resultant disablement to be timely. The treatment records note "chronic cough" while he was still working as a coal miner. The testimony supports the position that if a miner suffers from CWP at any time in his life, it is more likely than not that it would have been in existence at some level when he ended his daily occupational exposure to coal mine dust. In addition, the x-ray read by Dr. Smith and Dr. Istanbouly was taken prior to the expiration of Petitioner's 1(f) period.

Based on the totality of the evidence, and the factual findings above, the Arbitrator finds that Petitioner met the requirements of Sections 1(d)-(f) of the Occupational Diseases Act.

Arbitrator Linda J. Cantrell DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC034789
Case Name	SAVICH, MILAN v. H&M INTERNATIONAL TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0148
Number of Pages of Decision	11
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Stephen Smalling
Respondent Attorney	G. Steven Murdock

DATE FILED: 4/20/2022

/s/ Deborah Baker, 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

MILAN SAVICH,

Petitioner,

vs. NO: 19 WC 34789

H&M INTERNATIONAL TRANSPORTATION,

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 whether Petitioner sustained an accidental injury arising out of and occurring in the course of his employment, whether Petitioner's current spine condition is causally related to the work injury, entitlement to Temporary Total Disability benefits, and entitlement to incurred medical expenses as well as prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 14, 2021 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $548.49 per week for a period of 80 3/7 weeks, representing October 18, 2019 through April 29, 2021, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses detailed in Petitioner's Exhibit 5, as provided in §8(a), subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for physical therapy and injection treatment as recommended by Dr. Ninan as provided in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 20, 2022

/s/ *Deborah J. Baker*

DJB/lyc

O: 4/13/22

43

/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC034789
Case Name	SAVICH,MILAN v. H&M INTL TRANSPORTATION
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	8
Decision Issued By	Gerald Granada, Arbitrator

Petitioner Attorney	Stephen Smalling
Respondent Attorney	G. Steven Murdock

DATE FILED: 5/14/2021

INTEREST RATE FOR THE WEEK OF MAY 11, 2021 0.03%

/s/ Gerald Granada, Arbitrator

Signature

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)

Milan Savich
Employee/Petitioner

v.

H&M International Transportation
Employer/Respondent

Case # **19** WC **034789**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Chicago**, on **April 30, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/14/2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**42,782.48**; the average weekly wage was $**822.74**.

On the date of accident, Petitioner was **41** 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 Section 8(j) of the Act.

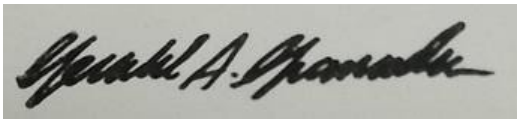
ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $548.49/week for 80 3/7 weeks, commencing 10/18/2019 through 4/29/2021 and shall pay the remainder of the award, if any, in weekly payments.
- Respondent shall pay reasonable and necessary medical services as delineated in P.X.5, as provided in Sections 8(a) and 8.2 of the Act to the Petitioner.
- Respondent shall authorize the physical therapy and injection treatment prescribed by Dr. Ninan as of 4/01/2021 referenced in P.X.2.

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

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

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



Signature of Arbitrator Gerald Granada

MAY 14, 2021

FINDINGS OF FACT

This case involves Petitioner Milan Savich, who alleges that he sustained injuries while working for the Respondent H&M International Transportation on October 14, 2019. Respondent disputes Petitioner's claims, and raises the following issues: 1) accident, 2) causation, 3) medical expenses, 4) TTD and 5) prospective medical care.

On November 5, 2018 Petitioner began his employment with the Respondent as an operations supervisor and was subsequently promoted to operations manager. Petitioner testified that his employer was engaged in the transportation industry working with railroad cars and truck trailers, primarily in railroad yards. He had previously worked as a plumber in his father in law's company until his father in law's passing.

Petitioner's job duties with Respondent included overseeing other employees and performing various physical activities involved with the loading/unloading of trailers onto railroad cars. The physical requirements of the job necessitated lifting, crawling, walking, and the climbing of ladders onto railcars. He worked 40 hours per week on the second shift. Petitioner testified that in the eleven months preceding his accident, he was fully capable of performing his job duties and had no physical issues which prevented him from doing so. He was not subject to any medical restrictions attributable to a back condition.

On October 14, 2019 Petitioner was in the process of placing derails on train tracks as part of his assigned duties. The derails were designed as a safety measure to prevent locamotives from entering areas wherein Petitioner and his co-employees were working on the tracks and railcars. The derails were made of steel and weighed anywhere from 15-55 pounds. Petitioner would physically lift the derail over and onto the track and affix it by pulling on a lever. After lifting a 25 pound derail, placing it onto the track, bending over and pulling the lever, Petitioner experienced immediate back pain which he described as stabbing in nature. The pain was so severe, it brought him to his knees. Petitioner then reported the accident to the employer in the facility utilized onsite. (P.X. 6) Petitioner attempted to work the following day and then sought medical treatment from his primary care Physician, Dr. Reji Ninan.

On October 18, 2019, the Petitioner saw Dr. Ninan. (P.X. 2) In his initial note, the history relates that on October 14, Petitioner was at work, pulling a lever when he experienced an acute onset of lower back pain. He was experiencing pain going down the right leg with intermittent numbness and tingling. (P.X. 2, p. 50) He was diagnosed with acute right sided back pain and sciatica for which he was prescribed Norco. On October 23, 2019 Dr. Ninan instructed Petitioner to go to the emergency room if the pain became unbearable. Dr. Ninan attributed his low back condition to the injury sustained at work. (P.X. 2 p. 48.)

Petitioner testified that the pain became unbearable so he was admitted to Lutheran General Hospital for the period October 24, 2019 through October 26, 2019. (P.X. 1). The history related that he had injured himself at work lifting equipment in a railroad yard and had pain radiating down the right leg and not subsiding. (P.X.1, pp. 3, 12) He was diagnosed with subacute back pain, lumbar DJD with lumbar radiculopathy. Following a neurosurgical consult, the records note Petitioner's preference to defer

surgery. The records further note Petitioner underwent a lumbosacral ESI at L5, (P.X.1, p. 7) and was discharged on October 26, 2019 with restrictions of no work until examination by his PCP. (P.X. 1, pp. 21-22)

Petitioner was readmitted to Lutheran General Hospital on November 1, 2019 with intractable back pain. (P.X. 1, pp. 25-26). The records from that visit indicate that Petitioner received little response to the previous ESI and that the pain medications were not working. (P.X. 1, pp. 29-31) It was determined that it was too soon for a repeat injection, so he was discharged with instructions for outpatient PT, remain off work and return in 3-4 weeks for another possible injection. (P.X. 1, p. 29)

Following his hospitalization, Petitioner remained under the care of Dr. Ninan, who prescribed PT, medications and restricted him from work. (P.x.1, pp 40-42) The decision was made to have Petitioner re-examined by neurosurgeon Dr. George Bovis on December 27, 2019. (P.X. 3). Dr. Bovis noted Petitioner was hurt at work in a railyard resulting in severe back pain getting progressively worse. He diagnosed Petitioner with lumbar herniations at L4-5 and L5-S1 along with annular tears producing severe low back pain and radiculopathy and opined he was a surgical candidate. Petitioner testified he is deathly afraid of undergoing surgery, so he proceeded conservatively with injections and PT. (P.X. 3). He was also instructed to consult with Dr. Mardjetko, should surgery become a consideration. (P.X. 3). Petitioner testified Dr. Mardjetko would not see him without authorization.

Petitioner testified his symptoms have never resolved following the accident. He has remained under the care of Dr. Ninan through the date of the hearing who has continuously prescribed injections, PT and medications. Dr. Ninan has also restricted the Petitioner from returning to work given the condition of his back. (P.X.2. pp. 59-66) Respondent denied the claim in its entirety and no benefits have been paid under the Act.

The medical evidence established that Petitioner had an extensive history of back related conditions necessitating treatment dating to 2008. (R.Xs. 1-13, 15) He has undergone MRIs, injections and been prescribed medication. In 2010 it was recommended he have a surgery which was never performed. (R.X. 15) The last medical record predating Petitioner's disputed accident with Respondent was on May 2, 2016 by Dr. Sekhadia. (R.X.12) It is noted therein that Petitioner had responded well to injections in the past and therefore an ESI was performed. Following that procedure, there are no medical records of any back related treatment in the approximate 3 ½ years leading up to the Petitioner's disputed accident with Respondent. (R.Xs. 1-12, 15)

At the direction of the Respondent, the Petitioner was examined by Dr. Steven Mather on September 17, 2020. (R.X. 14) Dr. Mather found he had sustained an injury to his back and felt Petitioner was suffering from a likely lumbar strain with lumbar degenerative disc disease. He opined that Petitioner had recovered back to his baseline condition preceding the accident. He further opined that the treatment received by Petitioner was reasonable and necessary and that he could return to work without restrictions. He felt the strain caused by the injury would have resolved three months post injury.

The Petitioner testified he desires to undergo the prescribed treatment of Dr. Bovis and Dr. Ninan

consisting of PT and injections to avoid surgery. He continues to experience back pain aggravated by sitting, standing and walking which radiates into his lower extremity. He requires daily pain medication and has not returned to work per his Doctor's restrictions. Petitioner testified he has sustained no other injuries or trauma to his back after the incident in question.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to ("C"), did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent, the Arbitrator finds the following:

The Petitioner was employed as an operations manager in a railyard whose job duties involved lifting, climbing, walking and crawling. The Petitioner testified he experienced excruciating pain in his back while lifting and installing a derail at work on October 14, 2019. Timely notice of the accident is not disputed by the Respondent. The evidence surrounding Petitioner's accident is undisputed and his testimony is corroborated by the histories contained in the initial medical records generated at the hospital and his PCP following his accident. (P.Xs. 1,2) Respondent produced no witnesses to contradict the Petitioner's testimony as it relates to his job duties, presence at the worksite on the date of the accident or his version of events. Based upon the foregoing, the Arbitrator finds that the Petitioner has met his burden on proving that an accident occurred that arose out of and in the course of Petitioner's employment by the Respondent on October 14, 2019.

In support of the Arbitrator's decision relating to ("F"), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The issue of causation is primarily based on the Petitioner's pre-existing back condition. The Petitioner had a history of back conditions necessitating treatment from 2008 through 2016. There is no evidence in the record that he received any treatment nor was he restricted in the three and one half year period preceding the accident. The evidence further establishes that he was fully capable of performing his job duties with the Respondent until October 14, 2019 when he sustained the subject injuries. Dr. Ninan, Dr. Bovis and Dr. Mather all concur he sustained injuries to his low back on that date. The fact that he had pre-existing conditions, even though the same result may not have occurred had the Petitioner been in normal health, does not preclude a finding that the employment was a causative factor. St. Elizabeth Hospital v IWCC, 371 Ill. App.3d 882, 885 (5th Dist. 2007). Every natural consequence that flows from an injury which arose out of and in the course of the Petitioner's employment is compensable under the Act. Cent. Rug & Carpet v. IWCC, 361 Ill. App.3d 684, 690 (1st Dist. 2005). It is also well-settled that an employee is fully entitled to benefits if a pre-existing condition has been aggravated, exacerbated or accelerated by an accidental injury. See Lopez v. Braner USA Inc., 07 W.C. 8678. Causation in a workers' compensation claim may be established by a chain of events showing prior good health, an accident and a subsequent injury. Schroeder v IWCC, 2017 Il App (4th) 160192WC. In Schroeder, the Petitioner had an extensive history of back injuries and treatment (including two surgeries) leading to a third surgical recommendation by her treating physician. On the eve of having surgery, Petitioner declined to go forward and instead discontinued treatment, secured her CDL and went to work for the Respondent as an over the road truck driver. Eight months later she fell and injured her back while working. This injury led

to surgery being performed and the imposition of permanent restrictions. In addressing the issue of causal connection, the Appellate Court utilized the "chain of events" analysis wherein a previous condition of good health coupled with an accident and subsequent injury may be sufficient circumstantial evidence to establish a causal nexus between the accident and the employee's injury. The Court further noted that if a Claimant is in a certain condition, an accident occurs and following the accident, the Claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. "The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been." Schroeder 79 N.E. 3d at 839. See also Duffin v. City of Chicago 21 I.W.C.C.0001.

The Arbitrator finds the facts herein support a finding of causation, consistent with the Appellate Court's decision in Schroeder. This Petitioner had gone for a period of three years (vs. eight months in Schroeder) without treatment or restrictions imposed on his activities. Unlike Schroeder, this Petitioner did not have a surgical recommendation when he was hired by the Respondent, but rather no treatment recommendations were in place. The last treatment having been performed in 2016 with no follow up or work restrictions recommended. (R.X. 12) It is undisputed Petitioner was fully capable of performing his job duties, without restrictions, until the accident of October 14, 2019. Since that time, he has been hospitalized twice, (P.X.1) prescribed PT and injections (P.X. 2, 3) together with a surgical recommendation. (P.X 3) His treating doctor has restricted him from all work activities since the accident and continues to do so. (P.X. 2, p. 66) In so holding, the Arbitrator acknowledges the opinions of Dr. Mather (P.X. 14) but does not find them as persuasive when compared with the totality of Petitioner's medical evidence and testimony. Dr. Mather found Petitioner had sustained a lumbar strain which resolved within weeks. The evidence establishes that Petitioner has never returned to the "baseline" he was at immediately before the subject accident. The diagnosis of a lumbar strain is not supported by the evidence and is contradicted by Dr. Ninan (P.X. 2), Dr. Bovis (P.X. 3) and Dr. Vayalil (P.X. 4). As noted in Schroeder, the salient factor is not the precise previous condition but rather the resulting deterioration from whatever the previous condition had been. The Petitioner went from a fully functioning individual able to perform his job duties to one who is disabled and in need of further medical treatment. The Arbitrator further notes that there was no medical evidence showing that Petitioner sustained any other injuries or trauma to his back subsequent to the accident in question. There has been no interruption in the Petitioner's consistent complaints of significant back pain following the accident necessitating ongoing treatment. Based on a totality of the Petitioner's medical evidence and his unrefuted testimonys, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his October 14, 2019 work accident.

In support of the Arbitrator's decision relating to ("J"), were the medical services that were provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

The medical expenses incurred in conjunction with the treatment of the Petitioner's back condition are contained in Petitioner's Exhibit 5. In Respondent's IME, Dr. Mather (R.X. 14) opined that through the date of his examination (09/17/2020), they were reasonable and necessary. There is no evidence that the charges detailed therein following the IME are unreasonable. Having found that the Petitioner's current condition of ill-being is causally related to the subject accident, the Arbitrator finds that the treatment

rendered in conjunction with that condition to be reasonable and necessary. Based on the foregoing, Respondent shall pay reasonable and necessary medical bills for services contained in P.X.5 to the Petitioner, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to ("L"), what temporary benefits are in dispute, the Arbitrator finds the following:

Following Petitioner's October 14, 2019 work accident, the he was examined by Dr. Ninan and twice admitted to the hospital within three weeks. (P.X. 1) Dr. Ninan instituted a course of conservative treatment and removed the Petitioner from his work in the entirety as of October 18, 2019. On November 18, 2019 he was examined by Dr. Bovis who deemed him a surgical candidate and prescribed pain management and PT in the interim. (P.X.3) Dr. Ninan continues to prescribe injections and PT for treatment of the subject injuries and continues the Petitioner off work. The period of temporary total disability is that temporary period following the accident during which an injured employee is either totally incapacitated from work by reason of the illness attending the injury or is subject to restrictions which cannot be accommodated by the employer. An injured employee will be considered temporarily totally disabled until such time as he has reached maximum medical improvement. Interstate Scaffolding vs. Illinois Workers' Compensation Commission, 236 Ill. 2d 132 (2010). The medical evidence established that the Petitioner has yet to reach maximum medical improvement for the subject injuries. Both the medical evidence and the Petitioner's unrebutted testimony establish that Petitioner is entitled to temporary total disability benefits under the Act. Based upon the foregoing, the Arbitrator finds that the Petitioner was temporarily and totally disabled for the period October 18, 2019 through April 29, 2021, the date of the hearing.

In support of the Arbitrator's decision relating to ("K"), is Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

Consistent with the Arbitrator's findings above, the Arbitrator further finds that the prospective medical care sought by Petitioner in the form of proposed injections and physical therapy prescribed by Dr. Ninan on April 1, 2021 (P.X. 2), are both reasonable and necessary to treat the Petitioner's back condition arising from his October 14, 2019 work accident. Respondent shall authorize and pay for this and such other reasonable medical treatment pursuant to the statutory fee schedule.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028364
Case Name	DIAZ, MARCO v. ATLAS EMPLOYMENT SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0149
Number of Pages of Decision	16
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jack Epstein
Respondent Attorney	ROBERT SMITH

DATE FILED: 4/20/2022

/s/Marc Parker, 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marco Diaz,

Petitioner,

vs. No. 18 WC 28364

Atlas Employment Services,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary disability and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission,* 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 48-year-old assembler, testified that on September 5, 2018 he injured his back while lifting a ladder to another table. He reported his accident, but was told to keep working as his shift was almost over. He called in sick the following day, a Friday, rested at home and took Tylenol. The following Monday, Petitioner came in to pick up his check and received paperwork allowing him to go to the company clinic, Concentra. There, he complained of bilateral low back pain radiating to his right abdomen and right thigh. Petitioner was diagnosed with abdominal and lumbar muscle strains, prescribed medication and physical therapy, and given a 10-lb lifting restriction.

Despite treatment, Petitioner's back pain did not abate. He stopped going to work because his restrictions weren't being honored. Dr. Mohiuddin took Petitioner completely off work on September 21, 2018 after Petitioner reported 9/10 pain and had positive bilateral SLR test. A lumbar MRI on October 2, 2018 revealed herniations and bulges at L4-5 and L5-S1.

On November 15, 2018, Petitioner saw Dr. Mash for a Section 12 examination. Dr. Mash opined Petitioner exhibited malingering behavior; that the findings on his MRI preexisted his accident, and that he was at MMI for any work injuries.

On February 1, 2019, Petitioner came under the care of spine surgeon, Dr. Koutsky, who diagnosed Petitioner with L4-5 and L5-S1 radiculopathy, related to his work injury. On May 24, 2019, Dr. Koutsky recommended Petitioner undergo a minimally invasive lumbar decompression, because his non-surgical treatments had failed to provide lasting relief.

While the Arbitrator found Petitioner proved accident, he found persuasive Dr. Mash's opinion that Petitioner reached MMI for his work injuries by November 15, 2018. The Arbitrator awarded Petitioner 8-6/7 weeks of temporary total disability, from September 21, 2018 through November 15, 2018. The Arbitrator denied TTD and medical expenses incurred after November 15, 2018, as well as the prospective surgery recommended by Dr. Koutsky.

The parties filed cross reviews. Respondent contends Petitioner did not prove accident; he was not a credible witness, and Dr. Mash's opinions were more persuasive than Dr. Koutsky's. In Petitioner's cross review, he argues the Arbitrator erred in finding he reached MMI on November 14, 2018. Petitioner also claims the Arbitrator erred by not awarding TTD, medical expenses and prospective medical care, after November 14, 2018.

The Commission agrees that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent on September 5, 2018, for the reasons stated in the Arbitration decision. The Commission affirms that finding. However, the Commission views the evidence differently than the Arbitrator regarding the issue of causation of Petitioner's condition on and after November 15, 2018, and modifies the awards pertaining to that issue.

Petitioner's objective tests showed his condition of ill-being was much more than the lumbar and abdominal muscle strains initially diagnosed at Concentra. A lumbar MRI taken one month after Petitioner's accident showed multilevel spondylosis, bulges, and herniations at L2-3, L4-5 and L5-S1 causing stenosis. Three and one-half months after that, on January 16, 2019, Petitioner's EMG test was reported as abnormal and showed evidence of left L5 and S1 radiculopathy. Although there was evidence Petitioner had preexisting degenerative disc disease, there is no evidence that he was symptomatic prior to his accident. Even if the accident did not cause his herniated discs, it clearly aggravated them and his condition, and necessitated treatment.

Although Dr. Mash found Petitioner reached MMI as of November 14, 2018, evidence shows Petitioner did not. Only days after that exam, Dr. Mohiuddin recommended Petitioner

receive lumbar injections. On December 20, 2018, Dr. Mohiuddin recommended a lower extremity EMG/NCV. That test, performed two months after Dr. Mash's exam, was abnormal.

Dr. Koutsky, a board certified orthopedic surgeon with a subspecialty in spine surgery, saw Petitioner as a patient on February 1, 2019. Then, Petitioner complained of low back pain radiating to his left lower extremity, with numbness, tingling and weakness. On exam, Dr. Koutsky found Petitioner had a positive left-sided SLR, with lumbar muscle tenderness, spasm and limited range of motion. Then, he recommended non-operative treatment of multiple injections and therapy.

On May 24, 2019, Dr. Koutsky again saw Petitioner, who was not doing better despite having undergone therapy and lumbar injections. Dr. Koutsky noted that Petitioner's October 2, 2018 MRI revealed a left paracentral disc herniation at L4-5 and a protrusion at L5-S1. Dr. Koutsky opined Petitioner's condition was causally related to his accident, and he found no signs of symptom magnification. Dr. Koutsky recommended Petitioner undergo a minimally invasive lumbar decompression procedure.

The Commission finds Dr. Koutsky's opinions more persuasive than Dr. Mash's, and that as of April 14, 2021, the date of the Arbitration hearing, Petitioner had not yet reached MMI. Dr. Koutsky's opinions were based upon Petitioner's symptoms being in an anatomically correct distribution, and his complaints being consistent with his MRI findings and an abnormal EMG. Objective evidence supports Dr. Koutsky's opinions. Dr. Koutsky kept Petitioner off work because of the pain medications he was taking, and to prevent further injury to Petitioner's discs.

Dr. Mash does not specialize in spine or lower back injuries, and has not performed a spine surgery in over 15 years. He admitted he did not review Petitioner's actual MRI films. Although Dr. Mash believed Petitioner showed signs of symptom magnification at his exam, no other treating doctors did. At Petitioner's first medical exam following his accident, Dr. Vlahos expressly noted Petitioner displayed no Waddell's signs. No evidence was offered to show Petitioner required any treatment to his low back prior to his accident.

For these reasons, the Commission finds Petitioner proved his lumbar condition of ill-being was causally related to his accident from September 5, 2018 through April 14, 2021. The Commission modifies the award of medical expenses to include the reasonable and necessary and medical bills related to Petitioner's lumbar spine treatment between those dates. The Commission also modifies the award of temporary total disability benefits, finding Petitioner entitled to that benefit for 133-6/7 weeks, from September 21, 2018 through April 14, 2021. Finally, the Commission reverses the Arbitrator's denial of prospective medical care, and finds Petitioner entitled to the prospective lumbar spine care recommended by Dr. Koutsky, including but not limited to lumbar decompression surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed August 6, 2021 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. Respondent shall pay Petitioner temporary total disability benefits of $387.40 per week for 133-6/7 weeks, for the period of September 21, 2018 through April 14, 2021, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical bills is modified. Respondent shall pay to Petitioner the unpaid reasonable and necessary medical bills related to his lumbar spine treatment which were incurred through April 14, 2021, pursuant to the Medical Fee Schedule, as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the denial of prospective medical care is reversed. Respondent shall authorize the prospective medical care recommended by Dr. Koutsky, including but not limited to lumbar decompression surgery.

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 shall pay to Petitioner interest under §19(n) of the Act, if any.

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

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

April 20, 2022

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-04/07/2022
068

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

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028364
Case Name	DIAZ, MARCO v. ATLAS EMPLOYMENT SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	11
Decision Issued By	Jeffrey Huebsch, Arbitrator

Petitioner Attorney	Jack Epstein
Respondent Attorney	Andrea Carlson

DATE FILED: 8/6/2021

/s/ Jeffrey Huebsch, Arbitrator
Signature

INTEREST RATE WEEK OF AUGUST 3, 2021 0.05%

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)

Marco Diaz Case # **18** WC **028364**
Employee/Petitioner
v.
Atlas Employment Services
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **April 14, 2021**. After reviewing all 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, **9/5/2018**, 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 $**2,905.50** the average weekly wage was $**581.10**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**1,549.68** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,549.68**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the Medical Fee Schedule, of $9,300.00 to Liberty Physical Therapy; 82.43 to Illinois Orthopedic Network; $524.60 to MidWest Specialty Pharmacy; and $1,950.00 to Berwyn Diagnostic Imaging, as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below.

Respondent shall pay petitioner temporary total disability benefits of $387.40 for 8-6/7 weeks, commencing September 21, 2018 through November 15, 2018, as provided in Section 8(b) of the Act.

Petitioner's claim for prospective medical treatment is denied.

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

/s/ Jeffrey B. Huebsch

Signature of Arbitrator

August 6, 2021

ICArbDec19(b)

FINDINGS OF FACT

Petitioner and Respondent's witnesses testified via a Spanish/English interpreter.

Petitioner was employed by Atlas Services, a temporary agency. He was working at Sure Built, a company that manufactures scaffolds and ladders, located in Bellwood, Illinois. He had been working at Sure Built for about 2 months, as of September 5, 2018. His job involved making ladders. He welded a little plate onto the ladder and then grinded the weld. He would lift the ladder part to position it to be welded, to grind it and to move the product to the next work table. Petitioner worked the 3:00 to 11:00 shift.

Petitioner was working this job on the date of the alleged accident, September 5, 2018. The shift was Wednesday afternoon into Thursday morning. Petitioner testified that he injured his low back late in his shift on September 5, 2018. He was lifting ladder parts from one table to another when he suffered his accident. Petitioner testified that he reported the accident to the person that gave him work orders on that day. Petitioner told this person that his back was hurting a lot and he couldn't stand it. The person told Petitioner to endure it, as the shift was almost over. Petitioner finished his shift. On direct examination, Petitioner said that he could not recall the name of the person that he told about the accident and on cross examination said that he reported the accident to Domingo.

Petitioner did not report to work the next day. He called the company that he was working at and advised that he was feeling bad. He couldn't get up. He did not go to work on the next day, a Friday. Petitioner testified that he could not even go to work on that Friday to pick up his check.

Petitioner did go to work on the following Monday, September 10, 2018. He picked up his check and requested a referral slip to go to Concentra. Petitioner was given the referral slip and went to Concentra on that day. This was the first medical treatment that Petitioner had for his alleged injuries. Petitioner said that he was examined, "but it was very little what they done."

Petitioner said that he thought that he worked the next day, Tuesday. He thought that he went to Concentra the following day, Wednesday. He was given a light duty slip. He worked the next day. He did not work the next day, a Friday, saying that he "went to work, but I came back home because I couldn't stand the pain."

Petitioner agreed that he did not seek medical treatment for his alleged injuries until 5 days after he sustained them.

The Concentra records show that Petitioner was seen for the first time on September 10, 2018. (PX 1) He provided a history of being injured lifting and twisting a 40 lb. item, resulting in back pain and decreased spine range of motion. The patient complained of bilateral low back pain and pain radiating to the right abdomen and right posterior thigh. The musculoskelatel exam shows complaints of 10/10 pain and pain shooting down the bilateral thighs. The neurologic exam was unremarkable. The diagnosis was lumbar and abdominal strain. Naproxen 500mg was dispensed. Work restrictions were provided and physical therapy was recommended. (PX 1)

Petitioner returned to Concentra on September 14, 2018, complaining that his back pain was getting worse and that he had pain radiating to his right mid to lower abdomen X-rays were reported as negative for fractures or abnormalities of the thoracic or lumbar spine. Petitioner reported that he was not working by his

choice. He was referred to the emergency room for unrelated glycemia. Work restrictions of work full shift, no lifting, sit down work 90% of the day were given. Petitioner was also evaluated for physical therapy on September 14. (PX 1)

The Application for Adjustment was filed on September 24, 2018, having been signed by Petitioner on September 17, 2018. (RX 3)

Petitioner testified that he next sought medical care at Illinois Orthopedic Network (ION). He testified that he came under Dr. Arayan's care and Dr. Arayan prescribed PT and he eventually came under the treatment of Dr. Shoeb Mohiuddin. Physical therapy helped, but pain continued. He was taken off work. Petitioner said that Dr. Mohiuddin gave him one injection, which resulted in less back pain. Thereafter, he was referred to Dr. Kevin Koutsky, who has recommended lumbar surgery.

Petitioner testified that he has 8-9/10 back pain. He said that he was fired from work ("There was no work given to me."). He is not currently working. Other than the few days that he worked after the accident, he has not worked. He would like to undergo the surgery recommended by Dr. Koutsky. He was paid TTD until he saw Dr. Mash for an IME.

The records of ION show that Petitioner began treatment there with Dr. Mohiuddin on September 21, 2018. (PX 3) Petitioner reported working at a factory as a machine operator. He reported "lifting a 30-pound beam about chest height and lifting it from one side of the neck and does this repetitive motion throughout the day. In his motion, he felt acute low back pain." The assessment was acute low back pain with associated bilateral lower extremity pain. An MRI was recommended and medication and physical therapy were prescribed. Petitioner was ordered off work. (PX 3)

The MRI of the lumbar spine was performed on October 2, 2018. The impression was:

- 1. Multilevel spondylosis with facet arthrosis and ligamentum flavum hypertrophy as above.
- 2. Broad-based posterior herniation at L4-5 causing moderate left and mild right neural foraminal and mild central canal stenosis.
- 3. Disc bulge with posterior herniation at L5-S1 causing moderate neural foraminal stenosis.
- 4. Broad-based posterior herniation at L2-3 causing mild left foraminal and left lateral recess stenosis. (PX 6)

At ION's order, Petitioner was evaluated for physical therapy by Chiropractor Dr. Delton Bazan-Peche at Liberty Physical Therapy on September 24, 2018. (PX 2) He reported that his injuries occurred while moving and lifting 50 lbs. metal bars. He reported that due to the constant lifting and pushing of heavy metal bars, he gradually developed burning in his lower back. "The patient sought the service of an attorney and he was referred to Illinois Orthopedic Network." Petitioner underwent palliative treatment at Liberty until July 17, 2019, per the chart notes and through November 5, 2019, per the submitted bill. (PX 2)

Petitioner was re-evaluated on October 12, 2018 by Dr. Mohiuddin. The MRI was reviewed. The recommendation was for a lumbar transforaminal epidural steroid injection at left L4-L5, L5-S1. Physical therapy and off work restrictions were continued. (PX 3)

Petitioner was examined at ION on November 19, 2018 by Dr. Mohiuddin. The assessment was L4-5, L5-S1 disk herniations with low back and left leg pain. He was pending a left L4-5 and L5-S1 transforaminal epidural steroid injection. He continued to be off work. Petitioner was re-examined on December 20, 2018. The injection continued to be recommended. Dr. Mohiuddin opined that Petitioner's lower back exam was consistent with the patient's complaints and the mechanism of injury that was reported at work. He was critical

of Dr. Mash's opinions. An EMG/NCV was also recommended. The EMG was completed on January 16, 2019. The testing showed evidence of Left L5-S1 lumbar spine radiculopathy. Petitioner was restricted from all work and pain injections, along with physical therapy were recommended. (PX 3)

Petitioner was examined on February 1, 2019 by Dr. Kevin Koutsky at ION. The history was that he was working in a factory setting and was lifting a 30-pound beam. He felt a sharp pain in his back radiating to his left leg. Petitioner advised that he did tell his supervisor about the injury. The diagnosis was Left L4-5, L5-S1 radiculopathy. Dr. Koutsky related the patient's condition to the September 5, 2018 work injury. Petitioner wished to exhaust all conservative treatment before considering surgery. Physical therapy continued to be recommended, and Dr. Koutsky also recommended a pain clinic evaluation and possible injections. (PX 3)

Petitioner was re-examined by Dr. Mohiuddin on February 22, 2019. The EMG indicated left L5-S1 radiculopathy. The recommendation was for a left L4-L5, L5-S1 transforaminal epidural steroid injection and followup two weeks later. There was a referral to Dr. Koutsky for surgical consultation. The injection was performed on April 1, 2019. Petitioner returned to Dr. Mohiuddin on April 12, 2019. He reported 50% relief following the injection. The recommendation was for a surgical evaluation, if there was poor efficacy from the injection. Petitioner received another lumbar epidural steroid injection at L5-S1 on April 22, 2019. It is noted that Petitioner testified that he had only one injection. He was re-examined on May 3, 2019 and reported relief. There was concern for neurological issues, and Petitioner was again referred for a surgical consultation. (PX 3)

Dr. Koutsky re-examined Petitioner on May 24, 2019. The diagnosis was: Left L4-5 and L5-S1 radiculopathy. Dr. Koutsky opined that the Petitioner had failed conservative treatment and recommended lumbar decompression/disckectomy. He did relate the surgery to the work injury. This was the last time Petitioner was seen by Dr. Koutsky. (PX 3)

At Petitioner's request, Dr. Koutsky testified by evidence deposition on June 17, 2019. (PX 7) Dr. Koutsky is a board certified orthopedic surgeon, with a subspecialty in spinal surgery. He also has an IME board certification. At the first visit with Petitioner, there were complaints of low back pain down the left leg and numbness, tingling and weakness. His diagnosis was left L4-5, L5-S1 radiculopathy. Dr. Koutsky recommended that Petitioner be off work at both exams. He recommended lumbar decompression surgery due to the failure of conservative treatment. The surgery was related to the work injury. The physical exam findings are consistent with the diagnostic studies. He did not think that Petitioner was malingering or faking. "This is a straightforward, classic case." Dr. Koutsky endorsed causation. The treatment to date was reasonable and necessary. He did not agree with Dr. Mash that Petitioner was at MMI as of November 15, 2018. (PX 7)

Petitioner testified that the IME exam of Dr. Mash lasted "Actually,10 minutes, about 5 minutes." The §12 examination took place on November 15, 2018. (RX 1) Petitioner testified that the physical exam by Dr. Mash was cursory, Dr. Mash examined his leg reflexes, tapped him on the shoulder, and that was the extent of the examination. The doctor examined Petitioner with the assistance of Spanish language interpreter. Petitioner testified that he was not asked any questions by Dr. Mash. He did testify that the interpreter did ask him questions, but he could not recall.

Dr. Steven Mash testified, via evidence deposition at the request of Respondent, on July 25, 2019. Dr. Mash is a board certified orthopedic surgeon. About half his practice is sports medicine (knees and shoulders) and half is general orthopedics. He stopped doing spinal surgery about 15 years ago. About 8 to 10% of his practice/income is associated with medicolegal matters. He is retained mostly by respondents. Dr. Mash testified that, in about 60% of the exams that he does his report is favorable to petitioners. (RX 1)

Dr. Mash testified that Petitioner provided a history and told of his complaints. Petitioner complained of low back discomfort relative to an injury which he sustained on the job on September 5, 2018, while working for Atlas temporary agency. Petitioner told Dr. Mash that he was assembling metal brackets and then transferring the brackets to another table, noted the parts weighed about 40 pounds, and he suffered a pulling sensation about his low back. Petitioner advised that several days later he had persistent low back discomfort and was then referred for evaluation by Concentra, where he was initially evaluated. Dr. Mash performed a medical record review and a physical examination of Petitioner. Dr. Mash described his physical examination of the Petitioner. Petitioner did stand with his knees and waist flexed, but would not demonstrate any further range of motion about the lumbar spine. Petitioner complained of discomfort. Dr. Mash further explained that Petitioner's sitting straight leg raising was recorded at 90 over 90. The supine test was to 80 degrees on the right and 20 degrees on the left. This is a dramatic inconsistency. Petitioner would not provide active range of motion about his left ankle. Additionally, the Gordon toe flexion test was positive, suggesting symptom magnification. Dr. Mash also reviewed the MRI report and described it as showing multilevel, multifocal degenerative disk disease, meaning the patient has arthritis throughout his back. Dr. Mash did not review the MRI film. He would review the actual film if he was contemplating surgery on one of his patients. (RX 1)

Dr. Mash diagnosed Petitioner with acute low back syndrome. He did not recommend a lumbar decompression surgery due to a lack of appropriate conservative care and medical management. Dr. Mash further testified that he would not operate on a patient with the malingering signs that were demonstrated during Petitioner's physical examination, because most of those patients will not improve. Dr. Mash opined that Petitioner had reached Maximum Medical Improvement as of the date of examination and was capable of full duty work. (RX 1)

An addendum report was authored by Dr. Mash, dated March 12, 2019 (Rx 1, Ex. 3). There was an apparent Ghere objection to the March 12, 2019 report at the deposition, but the objection was waived when the deposition transcript was tendered into evidence at the arbitration hearing. Dr. Mash reviewed additional medical records including Dr. Mohiuddin, and EMG testing carried out on January 16, 2019. Dr. Mash testified that following the review of these records, his opinion regarding future medical care had not changed. He did not endorse any surgical intervention. Assuming the Petitioner's examination had remained the same, including the symptom magnification, Dr. Mash opined that he continued to not agree with the recommendation for surgery. Dr. Mash opined that Petitioner was capable of returning back to work without restrictions. He further testified that the Petitioner had reached Maximum Medical Improvement without any permanent impairment as of the time of his examination of Petitioner in November of 2018. (RX 1)

Dr. Mash authored an additional addendum report dated September 19, 2019 (2 months after the deposition). It was attached to RX 1, but it was not marked or identified at the deposition (for obvious reasons). It was not mentioned in the tender of RX1 (to which there was no objection, although Petitioner did not agree with the opinions and findings set forth in the reports). Given the above, The Arbitrator the Arbitrator does not consider the September 19, 2019 report in deciding this case and does not accept it into evidence. If the Commission disagrees, so be it, as it certainly is within its prerogative.

Respondent submitted the testimony of 2 witnesses, Domingo Orozco and Luis Garcia.

Mr. Orozco testified that he worked at a metal company for 6 years and was working for Respondent on the date of the alleged accident. He remembered working with Petitioner. Orozco stated that he saw Petitioner at the arbitration hearing and "for what I see, he's in pretty bad shape from his low back." Orozco did not witness an accident on September 5, 2018 and Petitioner did not report an accident to him on that date. Orozco heard about Petitioner being injured, about 2 or 3 days later, from the day supervisor, Daniel, who sometimes stays in the afternoon. Orozco filled out page 2 of the accident report (RX 2). Orozco is a floating machinist, a

co-employee of Petitioner. He was not Petitioner's supervisor. There is a lead on the second shift, but he really doesn't have any English skills. Daniel speaks Spanish and English. Petitioner may have mentioned his back hurting to Orozco.

Mr. Garcia is employed by Sure Built as a supervisor for medical fabrications on the first shift. He has worked there for 20 years. He is also known as Daniel. As a supervisor, he was responsible for taking accident reports and filled out page 1 of RX 2 with the assistance of someone else. Garcia asked Domingo Orozco to fill out page 2 of RX 2. The report does state that the employee lost time due to the injury. The accident involving Petitioner should have reported by the 2nd shift supervisor, but he doesn't know English. Orozco told Garcia that Petitioner's back was hurting him and he left. Petitioner was not available to fill out RX 2.

Neither Party submitted the testimony of the 2nd shift supervisor and no witness provided that supervisor's name.

CONCLUSIONS OF LAW

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

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

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

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on September 5, 2018.

The Arbitrator bases this finding on the testimony of Petitioner and Respondent's witnesses, along with the records of Concentra.

It was Petitioner's testimony that he suffered an accident when lifting ladders on September 5, 2018. There was not a lot of detail regarding the "accident", but the Arbitrator will accept Petitioner's testimony and infer that he did injure his back lifting "ladders" from one table to another as part of his work duties for Respondent on September 5, 2018.

Domingo Orozco testified that he did not witness an accident on September 5, 2018 and Petitioner did not report a work-related accident to him on September 5, 2018. But, Petitioner may have mentioned his back

was hurting him. Orozco heard about Petitioner being injured 2 or 3 days later when he was questioned by the morning supervisor, Daniel. Daniel asked Orzoco to fill out page 2 of RX 2. Orozco could not identify Daniel as Luis Garcia. Orozco did confirm that the pieces on the line weighed 30 to 40 pounds and they are lifted from one area (table?) to another in the manufacturing process.

Luis Garcia did not interview Petitioner about the injury. He was not the second shift supervisor. Orozco told Garcia that Petitioner's back was hurting him and Petitioner had left work..

All of the witnesses who testified were unsophisticated and the testimony elicited was underwhelming and lacking in detail. Considering all of the testimony, the Arbitrator does believe that Petitioner suffered a lumbar strain as a result of lifting and twisting a 40 pound object while working for Respondent on September 5, 2018.

The slight delay in Petitioner seeking medical treatment does not convince the Arbitrator that Petitioner was not injured at work as he alleges. The slight difference in Petitioner's description of the mechanics of his injury to the various medical providers is of minor consequence and does not persuade the Arbitrator that no lifting injury occurred.

The records of Concentra (PX 1) do support Petitioner's claim. The history was of low back and abdominal pain after lifting and twisting a 40 pound object. The physical exam was consistent with the diagnosed lumbar strain and abdominal muscle strain.

Considering all of the evidence adduced, Petitioner proved that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on September 5, 2018.

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

Petitioner's current condition of ill-being is, in part, causally related to the work injury of September 5, 2018, to wit: resolved lumbar strain and abdominal strain/acute low back syndrome at MMI as of November 15, 2018 as described by Dr. Mash and as documented in the Concentra records.

The Arbitrator finds Dr. Mash's opinions to be persuasive in this case. Petitioner attempted to minimize the PE that Dr. Mash performed and the Arbitrator finds Petitioner's testimony regarding the exam to be not credible. Dr. Mash's testimony regarding the inconsistencies in Petitioner's exam on November 15, 2018 is found to be credible in this case and dooms Petitioner's claim for disability and medical benefits subsequent to the IME date. If Petitioner's PE was consistent (as opposed to the inconsistent SLR, seated/supine, Gordon toe flexion test grossly positive, failure to make an effort to perform requested movements, etc.), Dr. Mash would have noted it. He is a board certified orthopedic surgeon who has now been in private practice for over 40 years. His diagnostic ability and medical opinions in this case are respected by the Arbitrator in this case. Of course, the likelihood of successful back surgery for a patient exhibiting the inconsistencies that Petitioner displayed at the IME exam is nil.

Dr. Koutsky's opinions are not persuasive in this case. First, he saw Petitioner for the first time some 3 months after Dr. Mash's exam. He did not note any symptom magnification or faking on Petitioner's part at that time and during the course of treatment of Petitioner. He did not see Petitioner in November of 2018 and did not offer compelling testimony as to why the Arbitrator should disregard the dramatic inconsistencies noted by Dr. Mash.

Any condition of ill-being regarding Petitioner's low back related to the September 5, 2018 work injury had resolved by November 15, 2018 and Petitioner was at MMI as of that date.

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:

Based upon the Arbitrator's finding above on the issues of accident and causation, Respondent shall pay the following bills: **$9,300.00 to Liberty Physical Therapy; 82.43 to Illinois Orthopedic Network; $524.60 to MidWest Specialty Pharmacy; and $1,950.00 to Berwyn Diagnostic Imaging.**

The claimed bill from Liberty PT is $26,975.00. (PX 1) The awarded portion is $9,300.00 for the time period of 9/24/2018 to November 14, 2018. As Petitioner is found to be at MMI as of November 14, 2018, the remainder of this bill is denied.

The claimed bill from ION is $24,554.62. (PX 3) The charges incurred before November 15, 2018 are awarded. The charges after November 15, 2018 are denied. The Arbitrator notes that the charge for 9/21/2018 is for "initial consultation" in the amount of $254.31. This bill was paid by insurance. The charge for 10/12/2018 is also for "initial consultation" in the amount of $254.31. This charge will be awarded in the amount of $82.43 (the charge set forth for "follow up exam" later in the bill. You can't have 2 initial consultations and a review of PX 3 reveals that 10/12/2018 was a follow up exam. The awarded ION bill is $82.43.

The claimed bill from MidWest Specialty Pharmacy is a balance of $5,245.48. (PX 4) The awarded bills are for 9/21/2018 and 10/18/2018 (total: $1,336.46, less payments of $734.22 = $524.60). If Respondent has already paid the Fee Schedule or agreed amount, then Respondent has satisfied this portion of the Bills Award.

The claimed bill from Metro Anesthesiologists is $4,130.88. (PX 5) This bill is denied, as it is for services rendered to Petitioner after the date of MMI.

The bill from Berwyn Diagnostic Imaging is $1,950.00 for the 10/2/2018 MRI. This bill is awarded.

This award is made in accordance with §§8(a) and 8.2 of the Act. The awarded bills are found to be reasonable and necessary to cure or relieve the effects of the injury and are found to be causally related to the injury. Respondent shall have a credit for all awarded bills that it has paid or satisfied.

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

Based on the Arbitrator's finding on the issue of causation, above, Petitioner's claim for prospective medical care 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:

Based upon the Arbitrator's findings on the issues of accident and causation, above, **Respondent shall pay Petitioner TTD benefits of $387.40/week for 8-6/7 weeks, for the time period of September 21, 2018 through November 15, 2018.**

Petitioner was excused from work by his treating physicians beginning September 21, 2018 and was found to be at MMI and released to full duty work by Dr. Mash as of November 15, 2018.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC033390
Case Name	FLETCHER, RONNIE v. KNIGHT HAWK COAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0150
Number of Pages of Decision	33
Decision Issued By	Carolyn Doherty, Commissioner, Deborah Baker, Commissioner

Petitioner Attorney	Roman Kuppart
Respondent Attorney	Julie Webb, Kenneth Werts

DATE FILED: 4/20/2022

/s/Carolyn Doherty, Commissioner

Signature

DISSENT

/s/Deborah Baker, Commissioner

Signature

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 Occupational Disease	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONNIE FLETCHER,

Petitioner,

vs. NO: 16 WC 33390

KNIGHT HAWK COAL, 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 occupational disease, causation, disablement, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

I. FINDINGS OF FACT

A. Background

Petitioner testified that he had a high school education and worked underground in coal mines for 44 years. He stated that he was regularly exposed to coal and rock dust, as well as to diesel fumes while working for American Coal. He also stated that his last day of employment for Respondent was April 4, 2016. On that date, he was 65 years old. Petitioner testified that on that last day, his job classification was that of an "outby," but that he ran a miner most of the time and thus actually working "inby." He further testified that on his last day, he was exposed to and breathed coal dust. Petitioner additionally testified that on that date he signed a quit slip to retire. According to Petitioner, he was getting tired of the dust and had gotten hurt two or three times near the end of his career, which played a bigger role in his decision.

Petitioner testified that he worked in the Eagle I and Eagle II mines in Shawneetown from April 1972 to 1974. He stated that he worked for Freeman United Coal at its No. 4 mine in

Pittsburgh from March 1974 to May 1987. He stated that he worked at American Coal from June 1988 through March 2004. Petitioner testified that he returned to work for Freeman at its Crown II mine in Farmersville from March 2004 through June 2007. He further stated that he worked for Respondent at its mine in Cutler, Illinois from June 2007 until he retired.

According to Petitioner, when he first started working in the mines, the dust was really bad. Petitioner stated that when he ran a miner, he could not see his hand in front of his face from the coal dust. He testified that while working at the Eagle I and Eagle II mines, he ran a shuttle car, roof bolted, and shoveled. He further stated that he would have to load 200 to 500 bolts on the roof bolter daily. Petitioner added that the roof bolts weighed five pounds each and came in bundles of five.

Petitioner testified that while working at Freeman's No. 4 mine, he worked as a laborer, roof bolter, and miner operator, with duties including rock dusting, shoveling on the belt, running machinery, and hanging high voltage cable. He testified that two or three people would help him hang the high voltage cable, which was six inches in diameter. He stated that he also would hang curtains, operate a scoop, and anything else Freeman wanted done. Petitioner described the dust conditions at the No. 4 mine as "super bad."

Petitioner testified that his main job duties at American Coal included working "outby," roof bolting, and running a miner. He stated that when he left American Coal, his job classification was mine examiner, inspecting the belts and walking no less than five miles a day. He stated that the ground was not level and that he had to step over things like water pipes and rock falls. Petitioner testified that the ground was not always dry and that he often had to go through standing water, which ranged in depth between an inch deep to over his knees. He added that examining American's long wall face was a pretty dusty job.

Petitioner further testified that when he went to work at Freeman's Crown II mine, he started as "outby" which included rock dusting, shoveling on the belt, and running the miner. He stated that while Freeman tried to keep the dust down, it was pretty dusty.

Petitioner stated that his job duties for Respondent were "outby" and included rock dusting, shoveling on the belt, hanging cable and curtains, driving ram cars, and running the miner. He testified that while doing his job classifications at Respondent, he would become short of breath. He clarified that he would not get down but that he had to stop and take five-minute breaks. He described all of his jobs in the coal mines as heavy manual labor. Petitioner testified that his job required him to bend, stoop, and squat, which caused him some breathing problems. He added that he is also a little heavy, which did not help.

Petitioner further testified that he first noticed a difference in his breathing when he was working at Freeman's No. 4 mine in the mid-1980s. He stated that he became worried at that time about getting out of the mines because of the dust. He explained that when he sat on the miner and could not see his hand in front of his face, he knew it could not be good for him. He stated that he noticed shortness of breath while shoveling on the belt, hanging the cable, and walking to examine the mine.

B. Medical Treatment

On October 18, 2013, Petitioner presented to Dr. Sean McCain at Southern Illinois Medical Care Associates (SIMCA), complaining of neck pain after a 300-pound boulder fell on his head at the mine. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath when walking or lying down. Petitioner was diagnosed with cervicalgia and a closed fracture of the phalanx of the foot. Dr. McCain referred Petitioner for orthopedic care.

On November 1, 2013, Petitioner had a two-week follow-up visit. Petitioner followed up with Dr. McCain regarding his neck pain. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath. Dr. McCain noted that an MRI of the foot was ordered and surgery was not recommended yet.

On November 15, 2013, Petitioner followed up with Dr. McCain regarding his neck pain. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath. The doctor ordered an MRI.

On December 2, 2013, Petitioner returned to Dr. McCain for a review of MRI results, culminating in a referral to neurosurgery. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath.

On January 16, 2014, Petitioner had a six-week follow-up with Dr. McCain and was diagnosed with cervicalgia. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner made no report regarding his respiratory system.

On March 19, 2014, Petitioner followed up with Dr. McCain after a rock fell on his head and foot. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath. Petitioner was diagnosed with cervicalgia, a closed fracture of the phalanx of the foot, and a backache.

On April 14, 2014, Petitioner returned to Dr. McCain at SIMCA regarding his neck and back injury, with his status generally unchanged. Abnormal weight gain and an acute respiratory infection were noted as problems.

On May 12, 2014, Petitioner followed up with Dr. McCain regarding his back and neck pain related to a rock falling on his head and back at work. Abnormal weight gain and an acute

respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi. Petitioner was referred to a neurosurgeon. RX4(392-95). On the same date, in a different treatment note, Petitioner complained of edema in his left leg and foot. Petitioner was prescribed Lasix.

On June 13, 2014, Petitioner revisited Dr. McCain at SIMCA, complaining of edema in his legs. Abnormal weight gain and an acute respiratory infection were noted as problems. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi. Petitioner's Lasix prescription increased.

On February 20, 2015, Petitioner visited Dr. Kennedy at SIMCA, complaining of right knee pain and swelling related to an injury when he was struck by a ram car. The doctor ordered an MRI for a suspected MCL injury. Abnormal weight gain is noted as a problem. An examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On May 13, 2015, Petitioner saw Dr. Kennedy at SIMCA regarding his neck pain, described as off-and-on since his work injury in 2013. Petitioner was prescribed Norco to use during flare-ups of pain. Abnormal weight gain is noted as a problem. Petitioner reported no cough or shortness of breath. The examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On June 19, 2015, Petitioner saw Dr. Michael Luy at SIMCA regarding his low back injury, reporting that he was going to chiropractic care and physical therapy and that his condition had improved somewhat. Abnormal weight gain is noted as a problem. Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath when walking or lying down. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On July 2, 2015, Petitioner presented to Dr. Clayton Ford for evaluation of a low back injury reportedly suffered on June 4, 2015 while picking up belt rollers at Respondent's mine. Pettiioner's BMI is listed as 33.2 kg/m2. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated normal breathing and sounds, with no wheezing, rhonchi, rales or crackles.

On August 6, 2015, Petitioner followed up with Dr. Ford regarding his lower back strain. A review of Petitioner's pulmonary system indicated no dyspnea or cough. An examination of the lungs indicated normal breath and voice sounds.

On August 25, 2015, Petitioner followed up with Dr. Ford regarding his low back pain, including a review of MRI results. A review of Petitioner's pulmonary system indicated no dyspnea or cough. An examination of the lungs indicated they were clear to auscultation.

On July 6, 2016, Petitioner met with Dr. Ford to discuss his GERD medication and urinary issues. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated normal breathing and sounds, with no wheezing, rhonchi, rales or crackles.

On August 16, 2016, Petitioner had a "welcome to Medicare" visit with Dr. Ford. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated normal breathing and sounds, with no wheezing, rhonchi, rales or crackles.

On August 19, 2016, Petitioner underwent a CT scan of the abdomen. The interpreting radiologist's findings included a few calcified pulmonary nodules compatible with prior granulomatous disease in the lung bases.

On August 31, 2016, Petitioner followed up with Dr. Ford regarding his June 2015 back injury. Petitioner reported taking Norco, though he tried to limit it to once daily, even though it was prescribed for up to twice daily. Dr. Ford noted that Petitioner was seeing Dr. Kennedy for treatment of a prior neck injury. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated normal breathing and sounds, with no wheezing, rhonchi, rales or crackles.

On October 30, 2015, Petitioner visited Dr. Nicole Kennedy at SIMCA to discuss a possible dosage increase for his Norco prescription. Petitioner reported no cough or shortness of breath. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On September 16, 2016, Petitioner saw Dr. Kennedy at SIMCA for a prescription refill related to a settled workers' compensation claim. Petitioner reported no cough or shortness of breath. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On November 15, 2016, Petitioner followed up with Dr. Ford regarding his back injury. Petitioner reported that he had not done any physical therapy for a year and had experienced increased pain when he did physical therapy with a chiropractor. He also reported increased pain when he did not take Meloxicam. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated normal breathing and sounds, with no wheezing, rhonchi, rales or crackles.

On February 1, 2017, Petitioner saw Dr. Kennedy at SIMCA for a prescription refill. Petitioner reported no cough or shortness of breath. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On February 21, 2017, Petitioner followed up with Dr. Ford regarding his GERD and osteoarthritis. Petitioner reported that taking Meloxicam for his back helped. A review of

Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On May 31, 2017, Petitioner was seen by Dr. Kennedy at SIMCA, following up on chronic neck pain related to an old work injury. Petitioner reported no cough or shortness of breath. The physical examination of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi.

On September 21, 2017, Petitioner saw Dr. Ford for a six-month follow-up on his GERD and osteoarthritis. Petitioner reported doing yard work and other jobs around the house. A review of Petitioner's pulmonary system indicated no coughing or wheezing. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On March 27, 2018, Petitioner followed up with Dr. Ford regarding osteoarthritis, GERD, allergic arthritis, and hyperlipidemia. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On April 24, 2018, Petitioner revisited Dr. Ford regarding his anxiety. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On May 23, 2018, Petitioner followed up with Dr. Ford regarding diagnoses of BPH, ED, and anxiety. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On June 26, 2018, Petitioner revisited Dr. Kennedy at SIMCA, his health status the same as his prior visit.

On July 17, 2018, Petitioner saw Dr. Ford for his annual Medicare wellness check. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On October 16, 2018, Petitioner saw Dr. Ford regarding blood in his urine and seeking a repeat urinalysis. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On January 22, 2019, Petitioner visited Dr. Ford, reporting increased arthritis pain in his right hand. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On May 21, 2019, Petitioner followed-up with Dr. Ford for a review of lab reports related to BPH, CKD, GAD, GERD, osteoarthritis and other conditions. Petitioner reported getting on his exercise bike for five minutes daily, though his knee hurt if he rode for too long. A review of

Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On September 24, 2019, Petitioner saw Dr. Ford for follow-up on BPH, CKD, GAD, GERD, and other conditions. Allergic rhinitis continued to be listed as an active problem. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On January 21, 2020, Petitioner saw Dr. Ford for his annual Medicare wellness check. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On June 23, 2020, Petitioner was seen by Dr. Ford for a review of reports (apparently related to a colonoscopy in February 2020). Petitioner was noted to have good exercise habits and was working from home. A review of Petitioner's pulmonary system indicated no dyspnea, cough or wheeze. The examination of the lungs indicated no wheezing, rhonchi, rales or crackles.

On July 21, 2020, Petitioner revisited Dr. Ford's office for a follow up on laboratory results and stress test results. Examination results for the lungs indicated no wheezing, rhonchi, rales or crackles.

C. Report, B-Reading, and Deposition Testimony by Dr. Henry Smith

On September 29, 2016, Dr. Henry K, Smith, D.O., a board-certified radiologist and certified B-reader, wrote Petitioner's counsel regarding his interpretation of Petitioner's chest X-ray. Dr. Smith read the X-ray as showing interstitial fibrosis of classification p/p, all lung zones involved bilaterally, of a profusion of 1/1. Dr. Smith saw no large opacities. The doctor also saw chest wall plaque in-profile B3 in the right lung versus an accentuated subpleural fat deposit. In the left lung, Dr. Smith noted apical pleural thickening as well as minimal chest wall plaque in-profile A/1 versus accentuated subpleural fat deposits. Dr. Smith's impression was of simple coal worker's pneumoconiosis (CWP) with small opacities. Dr. Smith's B-reader report indicates that he concluded the film quality of the X-ray obtained on September 29, 2016 was Grade 1.

On February 3, 2020, Dr. Smith testified by deposition on behalf of Petitioner. Dr. Smith generally testified consistently with his report. He noted that he has been certified as a B-reader since 1987 and remains certified through July 31, 2023. He stated that he failed his fourth or fifth re-certification examination twice, back-to-back, which he attributed to needing new eyeglasses and then getting used to new eyeglasses. He added, however, that he re-took the examination and his certification never lapsed. He also stated that he had radiology privileges at multiple hospitals and was a consulting radiologist and B-reader for multiple occupational medical clinics.

Dr. Smith testified that when performing a B-reading, he starts with determining the quality of the film, with Quality 1 being "pretty much perfect, Quality 2 having issues with positioning or

artifacts, Quality 3 being readable but "not the best," and Quality 4 being unreadable. He also explained that over- or under-exposure of the film may misrepresent the amount of disease present. He stated that he then determines whether there are any small opacities present and if so, whether there are enough to be called pneumoconiosis. He also stated that the opacities associated with CWP may be round and are categorized as size "p" (up to 1.5mm), "q" (up to 3mm) and "r" (greater than 3mm). He added that asbestos-related pneumoconiosis is characterized by linear or irregular opacities which get characterized as "s," "t," or "u." He explained that the ILO B-reader form allows for primary and secondary opacities, expressed as a numerator and denominator such as "p/q." Dr. Smith testified that in CWP cases, the opacities occur primarily in the upper- to mid-lung zones, while asbestos-related cases are primarily in the mid- to lower lung zones. He stated that the next thing he considers is the profusion, which is the concentration or density of the findings in the lungs, explaining that a film showing CWP would be graded between 1/0 and 3/4, with the numerator indicating the type of opacities and the denominator indicating the amount of opacities. He further stated that he would then check for large opacities and plaques indicative of pleural disease. He agreed that 0/1 and 1/0 profusion ratings are usually the most controversial and that similarly qualified physicians could read the same film differently.

Dr. Smith confirmed that his impression of Petitioner's film was of interstitial fibrosis of classification p/p, all lung zones involved bilaterally, of a profusion of 1/1. He opined that Petitioner had CWP and resulting lung damage. He reiterated that he graded the film as Quality 1 and did not see any scapular overlay or improper positioning on the film.

On cross-examination, Dr. Smith testified that he had failed his fourth of fifth re-certification examination by overreading and finding more disease than was present on the test film. He stated that of his medical-legal work, approximately 80% was performed on behalf of claimants. He also stated that he was currently reading approximately 1,500 films per year. He agreed that he never sat on any committee with NIOSH or held any office with the College of Osteopathic Medicine or the Osteopathic Board of Radiology. Dr. Smith further testified that he takes the syllabus for the B-reading or re-certification examination as gospel. He stated that the panel that assembles the syllabus are the peers that he aspires to be. He agreed that the leaders in the field have been chosen to put that syllabus together. Dr. Smith testified that Dr. Cris Meyer was one of the authors of the new syllabus authored for NIOSH. He also agreed that the lung scarring indicated by opacities was permanent and the opacity size and profusion will not regress. Conversely, he agreed that pneumoconiosis is unlikely to progress once the exposure ceases. He further agreed that the small rounded opacities usually involve the upper lung zones first and as the dust exposure continues, all the lung zones may become involved. Dr. Smith did not know whether the monitors he uses for interpreting digital films were in compliance with the guidelines set forth in the Code of Federal Regulations.

D. Evaluation and Deposition Testimony by Dr. Suhail Istanbouly

On May 23, 2017, Petitioner presented to Dr. Suhail Istanbouly for a CWP evaluation. Dr. Istanbouly took a brief work history from Petitioner and noted that Petitioner was a smoker for 20

years, ending in 1996. He also noted that Petitioner owned a dog. Petitioner did not recall being diagnosed with asthma or COPD in the past. Petitioner reported that he was not on any inhaled or nebulized bronchodilator for respiratory problems. Petitioner also reported having an intermittent cough for years, triggered by brisk walking or other strenuous activities. He described the cough as mild to moderate, mostly dry with no significant sputum production or hemoptysis. He further reported no orthopnea or nocturnal dyspnea. He additionally reported exertional dyspnea for at least six months, becoming short of breath by walking a quarter-mile. Petitioner reported no wheezing, chest pain or tightness. Dr. Istanbouly reviewed the September 29, 2016 X-ray and noted Dr. Smith's impression of CWP. Dr. Istanbouly also noted that spirometry testing in his office revealed moderate ventilatory limitation with FEV1 2.61L, 67% predicted, FVC 3.58L, 68% predicted, and FEV1/FVC 73%.

Dr. Istanbouly assessed that Petitioner had simple CWP related to long-term coal dust exposure, noting that the diagnosis was confirmed by the chest X-ray and pulmonary function test (PFT) findings. He opined that CWP seemed to be a significant contributor to Petitioner's chronic respiratory symptoms (chronic intermittent cough and exertional dyspnea). He also advised that Petitioner avoid any further coal dust inhalation to minimize the progression of the disease.

On August 24, 2018, Dr. Istanbouly, who specializes in pulmonary medicine and critical care medicine, testified by deposition on behalf of Petitioner. Dr. Istanbouly testified that 30% of his practice involved the treatment of coal miners. He stated that performs black lung examinations for the U.S. Department of Labor. He also stated that he has been the medical director of the pulmonary department at Herrin Hospital since 2005. He added that he is the director of the Intensive Care Unit at Carbondale Memorial Hospital and has been the director of the Intensive Care Unit at Herrin Hospital.

Dr. Istanbouly's testimony regarding his evaluation of Petitioner was consistent with his report. He also testified that he would expect a person with simple CWP to have chronic respiratory symptoms, including a chronic cough, sputum production, exertional dyspnea, and wheezing. He further stated that it is not unusual for miners with early stage simple CWP to be asymptomatic and not know they have it. Dr. Istanbouly found that Petitioner had decreased breath sounds evidencing reduced air bilaterally, which he related to simple CWP. He testified that the PFT findings were valid and could be related to restrictive or a mixed restrictive and obstructive defect in Petitioner's case, but that it was not known whether it was truly restrictive because lung volumes were not taken. He opined that the "main culprit" in Petitioner's moderate ventilatory limitation was long-term exposure to coal dust, though Petitioner's history as a smoker could not be ignored. He additionally stated that a person with simple CWP could have PFT results in the normal range, especially at the early stages. He agreed that spirometry tested the global function of both lungs, rather than focal impairment of a portion of a lung.

Dr. Istanbouly also testified that one does not have to be a B-reader to diagnose someone with CWP and that he relied on his training and experience to diagnose it. He agreed that he was not an A-reader or a B-reader. He stated that the nearest B-reader was approximately 100 miles

away from him. Dr. Istanbouly further testified that he is familiar with the AMA Guides for Evaluation of Permanent Impairment, Sixth Edition (Guides) and that based on Table 5-4 in the Guides, Petitioner fit into Class 2 impairment due to his FVC. He agreed that CWP can cause permanent scarring or fibrosis which prevents the healthy function of lung tissue. He opined that Petitioner had clinically significant pulmonary impairment based on his cough and exertional dyspnea. He also opined that Petitioner had lung damage as a result of long-term exposure to coal dust.

On cross-examination, Dr. Istanbouly agreed that he had performed five to seven black lung evaluations monthly, always at the request of a claimant's attorney, though the number had declined recently. He also agreed that Petitioner had no history of respiratory disease. He further agreed that Petitioner did not report symptoms being triggered by smoke, dust, or fumes. Dr. Istanbouly testified that exertional dyspnea can result from causes other than respiratory disease. He stated that his examination of Petitioner's chest did not detect any adventitious sounds, wheezing, crackles, or rales. He agreed that Petitioner did not report leaving work due respiratory disease or symptoms.

E. Report, B-Reading, and Deposition Testimony by Dr. Cristopher Meyer

On October 2, 2017, Dr. Meyer, a board-certified radiologist and B-reader, authored a report and B-reading for Petitioner's counsel evaluating the September 29, 2016 chest X-ray, which he graded as Quality 2 based on improper positioning and scapula overlap. Dr. Meyer found that the lungs were well-expanded without small, rounded, small irregular, or large opacities. He noted a calcified granuloma at the right base, as well as apical thickening on the left. He further noted bilateral extra-pleural fat on the right greater than the left.

Dr. Meyer's impression was of no radiographic findings of CWP, adding that the X-ray was interpreted in compliance with the Code of Federal Regulations. He added that after completing his findings and the ILO B-reading form, he reviewed a narrative summary and B-reading form completed by Dr. Smith regarding Petitioner's X-ray. Dr. Meyer reiterated that the film was Quality 2, not Quality 1 as indicated by Dr. Smith. Dr. Meyer also disagreed with Dr. Smith's reported findings of small opacities of size "p" with a profusion of 1/1. Dr. Meyer wrote that the lungs are clear. He added that the smooth opacity along the lateral chest walls, right greater than left, has the characteristic appearance of extra-pleural fat and no pleural plaque and was not a manifestation of coal dust exposure. He also reiterated that this was a normal examination with no findings of CWP.

On August 8, 2018, Dr. Meyer testified by deposition on behalf of Respondent. He testified that he has been a board-certified radiologist since 1992. He also stated that he has been a B-reader since 1999. According to Dr. Meyer, he was asked to take the B-reading exam by Dr. Jerome Wiot, who was part of the original committee that designed the teaching course that was called the B-reader program. He testified that as a member of the American College of Radiology Pneumoconiosis Task Force, he helped complete a new syllabus for the B-reader program, as well

as a test that was delivered to NIOSH in 2017. Dr. Meyer testified that the faculty for the B-reading course is typically comprised of experienced senior level B-readers. He stated that the B-reader examination has approximate 60% pass rate, though generally radiologists have a 10% higher pass rate than other specialties such as occupational doctors and pulmonologists. He opined that he thought radiologists had a higher pass rate because they were more practiced at reading X-rays.

Dr. Meyer testified that a B-reader first evaluates the quality of the film to describe any limitations of the X-ray, then looks at the lungs to determine whether there are any small nodular opacities and, if so, give them a letter score based on their size and appearance. He distinguished "p," "q," as "r" as nodular opacities differing from "s," "t," and "u" as linear opacities. Dr. Meyer testified that CWP is characteristically described by small round opacities, while diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. He further stated that B-readers describe the distribution of the opacities, because different pneumoconioses are seen in different regions of the lung. According to Dr. Meyer, CWP is typically an upper-lung zone predominant process, whereas idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. He stated that the final component of the X-ray interpretation is the extent of lung involvement, or so-called profusion, which he described as an attempt to describe the density of the small opacities in the lung. He testified that the classifications of profusion range from 0/0, which is normal, through 3/+, which is the most abnormal profusion. Dr. Meyer later added that a 1/0 reading was normal, right on the borderline between abnormal and normal. He stated that one of the most important parts of the interpretation is making the distinction between a 0/0 or 0/1 normal examination and a 1/0 slightly abnormal examination.

Dr. Meyer's testimony regarding his examination of Petitioner's X-ray was consistent with his report. He clarified that the calcified granuloma at the right lung base and the apical thickening he identified would be associated with tuberculosis or histoplasmosis (a fungal infection) which he did not attribute to Petitioner's exposure to coal dust.

On cross-examination, Dr. Meyer agreed that a B-reader is preferred to an ordinary radiologist when interpreting an X-ray for the presence or absence of an occupational disease. He also testified that CWP typically begins in the upper-lung zones, but can extend down to the bases when it is extensive. He later testified that he was aware of a recent study which might disagree with that finding, but described what he thought were significant problems with the study, such as a lack of pathologic proof and inadequate data on smoking histories. He agreed with the study's statement that individual coal macules are generally too small to be appreciated on chest X-rays, adding that most of the nodules seen on chest X-rays are summation shadows formed by multiple coal macules. He acknowledged that mild simple CWP is generally asymptomatic. He also agreed that a negative film for CWP does not necessarily rule out the disease. He further agreed that many coal miners have had negative chest x-rays for CWP, but on biopsy or autopsy it is shown they had CWP pathologically.

Dr. Meyer also acknowledged that he did not pass the B-reader examination when he first sat for it when he was in the military, years prior to 1999. He agreed that an intelligent physician with extensive knowledge and training in occupational diseases could fail the B-reading examination easily because the test was quite challenging. He also agreed that similar experts with similar credentials may disagree on the reading of chest films, especially in Category 1.

On redirect examination, Dr. Meyer testified that simple CWP typically will not progress once exposure ceases. Regarding his initial failure of the B-reader examination, he explained that in approximately 1994, his commanding officer at the hospital told him that he was going to take the test, and he had no idea that he was supposed to study.

F. Pulmonary Function Testing by Dr. Jeff Selby

On October 16, 2017, Petitioner underwent a pulmonary function test at Methodist Hospital ordered by Dr. Jeff Selby. The report states that Petitioner's FVC was 4.66 liters (87% predicted), with an FEV1 of 3.43 liters (81% predicted) and an FEV1% of 74%. After administering bronchodilators, the FVC was 4.67 liters (87% predicted), with an FEV1 of 3.57 liters (84% predicted) and an FEV1% of 76%. The DLCO was 99% predicted, 129% predicted when correcting for lung volumes. The report also stated that Petitioner was unable to meet standards on the PEF on the Pre-FCV and the FEV1 and the post-FVC in spite of multiple attempts. Dr. Selby indicated the spirometry and diffusion capacity was normal.

G. Report, B-Reading, and Deposition Testimony by Dr. David Rosenberg

On March 5, 2018, Dr. David Rosenberg authored a report and B-Reading for Respondent's counsel regarding whether Petitioner had any pulmonary disease or impairment as a consequence of his occupational exposure. Dr. Rosenberg summarized Petitioner's medical records dating back to October 2013. He also summarized the reports and B-readings authored by Dr. Smith and Dr. Meyer, as well as the evaluation by Dr. Instanbouly. He wrote that the PFT results included in Dr. Istanbouly's evaluation were invalid because: (1) incomplete efforts were evident based on the shape of the flow-volume and volume-time curves; and (2) the two best FVC values varied by 200cc (3.38 liters and 3.58 liters). He added that the study was invalid based on ATS criteria. However, Dr. Rosenberg wrote that the October 16, 2017 PFT ordered by Dr. Selby appeared to be valid.

Dr. Rosenberg also reviewed the September 29, 2016 chest X-ray, grading it as Quality 1. His impression was that the lung fields revealed no parenchymal changes of a pneumoconiosis, though slight basilar scarring was observed. He interpreted the X-ray as a 0/0 film.

On August 27, 2018, Dr. Rosenberg testified by deposition on behalf of Respondent. Dr. Rosenberg has been board-certified in internal medicine since 1977, in pulmonary diseases since 1980, and in occupational medicine since 1995. He stated that he also obtained a Master's of Public Health in 1996. Dr. Rosenberg also stated that he became a B-reader in 2000. He testified

that he has performed examinations for the U.S. Department of Labor. Dr. Rosenberg added that he remained a medical specialist for the Social Security Administration and the Industrial Commission of the State of Ohio. He estimated that when examining at the request of counsel, 95% of his work has been for industry. He also estimated that administrative or medical-legal evaluations constituted approximately 10% of his practice. He stated that he had between 10 and 20 black lung patients in his clinical practice out of 1,000 to 2,000 patients.

Dr. Rosenberg generally testified consistently with his record review and B-reading of Petitioner's chest X-ray. He also stated that there was no diagnosis of COPD or chronic bronchitis in the medical records he reviewed. He also stated that diagnoses should not be rendered on the invalid testing such as the spirometry conducted for Dr. Istanbouly's evaluation. Dr. Rosenberg explained that a flow-volume curve should peak early and decline at roughly a 45-degree angle and that Petitioner's flow-volume curves during Dr. Istanbouly's evaluation were wavy. He stated that the PFT performed five months later at Methodist Hospital was valid and did not reveal any indication of restriction. Dr. Rosenberg testified if he were to apply the results obtained in the spirometry performed at Methodist Hospital to the Guides for the Evaluation of Permanent Impairment, Sixth Edition, Petitioner would fall in category 0 for impairment.

Dr. Rosenberg reiterated his impressions that the September 29, 2016 X-ray was a Quality 1 film which he interpreted as 0/0 and thus negative for pneumoconiosis. He stated that a 1/0 or greater reading was required for an impression of pneumoconiosis. He also described the profusion as important because it reflected the intensity of the observed changes. He also stated that it would be unlikely for simple pneumoconiosis to progress once the exposure ceased. Dr. Rosenberg added that sub-radiographic pneumoconiosis probably has no clinical significance. He opined that Petitioner's 99% diffusion capacity supported the conclusion that there was no interstitial changes or chronic scarring in the interstitium disrupting the alveolar capillary bed. He opined that Petitioner has no respiratory impairment related to past coal dust exposures and clearly does not have any pulmonary disease or impairment consequent to occupational exposures.

On cross-examination, Dr. Rosenberg agreed that there is no cure for coal workers' pneumoconiosis and the scarring and fibrosis is permanent. He stated that CWP could progress in the absence of further exposure, but it is unusual. He also agreed that a person could have coal workers' pneumoconiosis without having chest x-ray evidence of the disease or know that they have the disease. Dr. Rosenberg further agreed that a person could have shortness of breath despite normal pulmonary function. He acknowledged that a person could have normal pulmonary function and have CWP, adding that most would have normal pulmonary function. Dr. Rosenberg testified that a person probably could lose a third of their lung function and have a normal pulmonary function testing. He also testified that a person could have a normal diffusing capacity and have simple coal workers' pneumoconiosis.

Dr. Rosenberg acknowledged that he did not take Petitioner's patient history or speak with his examining or treating doctors. He also stated that he did not perform a physical examination of Petitioner or perform any testing. He agreed that similarly qualified physicians can and do

disagree as to the findings on chest x-rays and that would especially be true in borderline cases of 0/1 or 1/0. Dr. Rosenberg also agreed that a physician does not have to be a B-reader to diagnose CWP. He added that B-reading was not designed for and should not be used for diagnostic purposes.

H. Additional Information

Regarding his current condition of ill-being, Petitioner testified that he still had breathing problems. He stated that if he were to go outside and walk on level ground at a normal pace, he could probably walk around a quarter of a mile before becoming short of breath. He estimated that he could probably climb a flight and a half of stairs before becoming short of breath. Petitioner testified that his breathing problems had worsened from the time he noticed them at Freeman's No. 4 mine. He stated that he was taking medication for respiratory complaints and also takes a lot of sinus medicine. He later testified that his family physician, Dr. Clayton Ford, would give him medication for respiratory infections, though Petitioner could not recall the name of the medication. Petitioner also stated that he takes medications to help him go to the bathroom and to control his blood. He later clarified that he took Flomax for his prostate, Atorvastatin for cholesterol, and Duloxetine for anxiety. He additionally testified that he had started smoking in 1970, but quit in 1995 because he had reached the point of smoking close to a pack of cigarettes daily.

Petitioner testified that his breathing affects ability to walk and perform yard work, requiring him to take breaks. He stated that he mows his one and one-half acre yard with a small tractor, while his wife usually does the "weed eating." Petitioner testified that it takes him longer to do the yard work today than it did 15 years earlier because of his breathing problems.

Petitioner also testified that his hobbies include deer hunting (with both bow and gun) and fishing. He stated that he may walk nearly a half-mile to reach his deer stand, but takes a couple of breaks to get there. He added that his deer blind is elevated. He later stated that he killed a couple of deer during the prior year. According to Petitioner, he would haul the deer away by vehicle and did not drag the deer himself. He also testified that he usually fishes with someone who will help launch his boat. Petitioner later testified that he had an exercise bike, but he did not use it enough because it bothered his breathing. He agreed that he weighed 278 pounds when he was examined by Dr. Istanbouly, 271 pounds when he was weighed at Methodist Hospital, and approximately 285 pounds on the hearing date.

Petitioner believed that it was fair to say that while working in the mines he completed his job every day, but at the end it was getting harder to do. Petitioner testified that he could not do any of his former coal mine jobs now. He testified that he had always performed manual labor and could not type or use a computer.

On cross-examination, Petitioner agreed that he was off work for a little while on disability for his leg after a ram car ran over him. He also stated he was also injured when a big rock fell

on his head. He could not recall if he was off work on disability until March 10, 2016. Petitioner testified that he is receiving Social Security and Medicare benefits and had not worked since retiring. He acknowledged that he also received a pension from the United Mine Workers for his employment with Freeman. He testified that he had a 401(k) plan from American Coal which was rolled into his 401(k) plan at Respondent.

Petitioner testified that while he was employed "at the mine," he underwent chest x-ray screening for black lung by NIOSH once. He stated that he received a letter with the screening results but did not bring the letter with him to the hearing and probably no longer possessed it.

II. CONCLUSIONS OF LAW

The Arbitrator concluded that Petitioner proved by a preponderance of the evidence that he suffers from CWP and that his current condition of ill-being is causally connected to his coal mine exposures. The claimant in an occupational disease case has the burden of proving both that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467 (2001). CWP is a slowly progressing lung condition caused by long-term exposure to coal dust and must be proven by medical documentation and opinion testimony. See *Zeigler Coal Co. v. Industrial Comm'n*, 237 Ill. App. 3d 213, 219 (1992); *Monterey Coal Co. v. Industrial Comm'n*, 241 Ill. App. 3d 386, 392-93 (1992). The question of whether a claimant has CWP is a question of fact to be established by competent medical evidence. *Id*. It is the function of the Commission to decide questions of fact, judge the credibility of witnesses, and resolve conflicting medical evidence. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*, 2013 IL App (5th) 120564WC, ¶ 21; *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). Interpretation of medical testimony is particularly within the province of the Commission. *Freeman United Coal Mining Co. v. Workers' Compensation Comm'n*, 386 Ill. App. 3d 779, 782-83 (2008).

A diagnosis of CWP is usually made upon the reading of a chest x-ray by a B-reader and the opinions of B-readers are generally considered more reliable than those of non-B-readers. Dr. Istanbouly is not a B-reader, and the Commission does not find his opinion that Petitioner developed CWP from coal dust inhalation as persuasive as did the Arbitrator. Dr. Istanbouly relied on PFT results which were facially invalid and were ultimately undermined by Dr. Selby's PFT. Dr. Istanbouly's own recitation of symptoms of CWP, including a chronic cough, sputum production, exertional dyspnea, and wheezing, are not supported by Plaintiff's symptoms of an intermittent dry cough and no wheeze. As such, the Commission does not rely on Dr. Istanbouly's opinions.

With regard to the B-reader opinions in this case, the Commission notes that Dr. Smith was the only B-reader who opined that Petitioner suffered simple CWP and his B-reading differs greatly from those of the other B-readers, Drs. Rosenberg and Meyer. Dr. Smith read the X-ray as showing a serious case of CWP based on interstitial fibrosis of classification p/p, all lung zones

involved bilaterally, and of a profusion of 1/1. The Commission notes, however, that both Dr. Meyer and Dr. Rosenberg interpreted the same X-ray as a normal 0/0 film showing no CWP.

Dr. Rosenberg not only conducted a B-reading, but also reviewed Petitioner's prior treatment records, which consistently indicate that Petitioner reported no cough, no wheezing, no rapid breathing, and no shortness of breath and that physical examinations of the lungs indicated no dyspnea, wheezing, rales, crackles or rhonchi. Petitioner's treatment records support the conclusion that Petitioner did not have a history of chronic respiratory issues and support Dr. Rosenberg's opinions. Dr. Meyer found that the lungs were well-expanded without small, rounded, small irregular, or large opacities. Dr. Meyer's impression was of no radiographic findings of CWP. He found the lungs to be clear. Given the entirety of the record, the Commission places greater weight on the opinions of Dr. Meyer and Dr. Rosenberg who each opined that Petitioner did not develop CWP.

Ultimately, the burden of proof is on Petitioner to establish that he suffers from CWP, not that CWP cannot be ruled out as a possibility. Having reviewed the record as a whole, the Commission concludes that Petitioner failed to prove by a preponderance of the evidence that he suffers from CWP.

Accordingly, Petitioner's claim for compensation is denied.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner failed to prove that he suffers from an occupational disease.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated June 28, 2021 is vacated and Petitioner's claim for compensation is hereby 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 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.

April 20, 2022
o: 3/3/22
CMD/kcb
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

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

DISSENT

I disagree with the majority's decision to reverse the Decision of the Arbitrator. The Arbitrator correctly found Petitioner was last exposed to an occupational disease (coal workers' pneumoconiosis) on April 4, 2016, which arose out of and in the course of his employment with Respondent and satisfied the requirements of Section 1(d) of the Illinois Workers' Compensation Act (the "Act"). The Arbitrator also correctly found that Petitioner was disabled within two years after the last day of his last exposure on April 4, 2016, thus satisfying the requirements under Section 1(e) and (f). I also agree with the Arbitrator's analysis under Section 8.1b of the Act, finding that Petitioner's coal workers' pneumoconiosis caused a five percent loss of the person-as-a-whole. Accordingly, I would affirm the Decision of the Arbitrator with clarifications.

Petitioner credibly testified that he has worked in the mines for a total of forty-four years, with approximately nine of those years for Respondent. Petitioner testified he continued to experience breathing problems since he left his employment with Respondent on April 4, 2016. Petitioner also testified that it currently takes him longer to perform regular activities and hobbies.

Dr. Smith, a NIOSH certified B-reader since 1987, reviewed the September 29, 2016 chest X-ray and opined that the film was quality 1, and it showed simple coal workers' pneumoconiosis with small opacities.

Dr. Istanbouly, a board-certified critical care and pulmonary medicine physician, also reviewed the same chest X-ray and opined that it was of diagnostic quality, and it revealed mild, bilateral interstitial changes consistent with coal workers' pneumoconiosis. Dr. Istanbouly agreed with Dr. Smith's B-reading report. Dr. Istanbouly examined Petitioner on May 23, 2017 and took a detailed history of Petitioner's employment. On physical examination, he found Petitioner had decreased breath sounds evidencing reduced air bilaterally. Dr. Istanbouly opined that Petitioner's decreased breath sounds were related to coal workers' pneumoconiosis. Dr. Istanbouly opined further that the pulmonary function studies showed moderate, nonspecific ventilatory limitation which was primarily caused by Petitioner's long-term coal dust inhalation. Ultimately, Dr. Istanbouly opined that coal workers' pneumoconiosis was a significant contributor to Petitioner's

chronic respiratory symptoms and opined, acknowledging that Petitioner had a history of smoking, that the main culprit was long-term exposure to coal dust.

On October 16, 2017, Petitioner underwent pulmonary function testing performed by Dr. Selby who found that Petitioner was unable to meet PEF, pre-FVC, FEV1, and post-FVC standards in spite of multiple attempts.

Dr. Meyer, a NIOSH certified B-reader since 1999, reviewed the September 29, 2016 chest X-ray and opined it was a quality 2 film due to improper positioning. Despite this finding, however, Dr. Meyer opined the film showed no coal workers' pneumoconiosis. On the other hand, Dr. Rosenberg, a board-certified internal medicine and pulmonary disease physician, opined that the same chest X-ray was a quality 1 film, and negative for coal workers' pneumoconiosis. Dr. Rosenberg opined that the pulmonary function testing was invalid.

Under Section 1(d) of the Act, Petitioner met his burden and proved exposure to the hazards of coal workers' pneumoconiosis where he worked in coal mines for a total of forty-four years (nine being with Respondent) based on the persuasive opinions of Dr. Istanbouly and Dr. Smith who both agreed that the September 29, 2016 chest X-ray was a quality 1 film and showed simple coal workers' pneumoconiosis. This is further bolstered by the incidental finding on the August 19, 2016 abdominal CT scan which showed calcified pulmonary nodules compatible with prior granulomatous disease in the lung bases. Significantly, Dr. Meyer and Dr. Rosenberg disagreed as to the quality of the September 29, 2016 chest X-ray, yet both opined that it showed no pneumoconiosis. Accordingly, I do not find the opinions of Dr. Rosenberg or Dr. Meyer persuasive. Based on the totality of the evidence, Respondent failed to rebut the presumption that Petitioner's coal workers' pneumoconiosis arose out of his employment. Further, based on totality of the evidence, Petitioner's condition is causally connected to his exposure.

With respect to disablement, Section 1(f) provides in relevant part that "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f) (West 2008). Section 1(e) of the Act provides two ways to establish disablement. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 25; *Forsythe v. Industrial Comm'n*, 263 Ill. App. 3d 463, 470 (1994). A claimant can establish disablement by showing "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e) (West 2008). Alternatively, section 1(e) defines disablement as "the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment." 820 ILCS 310/1(e) (West 2008). Under Sections 1(e) and 1(f) of the Act, I agree that Petitioner established timely disablement based on his stated impairment in function, which is corroborated by the findings on the September 29, 2016 chest X-ray as interpreted by Dr. Smith and Dr. Istanbouly, and his inability to return to coal mining without further endangering his health.

Notwithstanding my agreement with the Decision of the Arbitrator in the above respects, I would clarify that Petitioner proved his entitlement to benefits under the Act by a preponderance of the evidence, based on the persuasive opinions of Dr. Istanbouly and Dr. Smith and the totality of the evidence in this case, regardless of whether Dr. Meyer and Dr. Rosenberg could "rule out" coal workers' pneumoconiosis.

For the above reasons, I respectfully dissent.

/s/ *Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC033390
Case Name	FLETCHER, RONNIE v. KNIGHT HAWK COAL LLC
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Roman Kuppart
Respondent Attorney	Kenneth Werts

DATE FILED: 6/28/2021

THE INTEREST RATE FOR THE WEEK OF JUNE 22, 2021 0.05%

/s/ Linda Cantrell, Arbitrator

Signature

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

RONNIE FLETCHER
Employee/Petitioner

v.

KNIGHT HAWK COAL, LLC,
Employer/Respondent

Case # **16-**WC-**033390**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, **Illinois** on **March 25, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 4, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,304.00**; the average weekly wage was $**1,352.00**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $**755.22 (Max rate)**/week for a period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused a **5% loss of Petitioner's body as a whole.**

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

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

June 28, 2021

Arbitrator Linda J. Cantrell

STATE OF ILLINOIS)
) **SS**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RONNIE FLETCHER,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 16-WC-033390
	)	
KNIGHT HAWK COAL, LLC.,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on March 25, 2021 on all issues. An Application for Adjustment of Claim was filed on November 1, 2016 wherein Petitioner alleges he sustained an occupational disease of his lungs and/or heart as the result of inhaling coal mine dust, including, but not limited to, coal dust, rock dust, fumes, and vapors for a period in excess of 44 years. The Application alleged a date of last exposure of April 4, 2016. The issues in dispute are accident, causal connection, the nature and extent of Petitioner's injuries, and Sections 1(d)-(f) of the Occupational Diseases Act. All other issues have been stipulated.

TESTIMONY

Petitioner testified he is 70 years old and has been married for 17 years. Petitioner has a high school diploma and performed underground coal mining for 44 years. Petitioner testified that his last day of employment with Respondent was on 4/4/16 at which time he chose to retire at the age of 65. He testified he decided to retire because he got tired of the dust and mostly because he sustained a couple of work-related accidents toward the end of his employment, including getting run over by a ram car. Petitioner has not looked for work since leaving his coal mine employment.

Petitioner testified he was regularly exposed to coal and rock dust while working in the coal mines. He was also exposed to diesel exhaust while working for American Coal. On the last day of his employment Petitioner's job classification was outby, but he ran a miner most of the time. Petitioner testified on his last day of employment he was exposed and breathed coal dust.

Petitioner began his coal mine employment in April 1972 for the Eagle Mines. From March 1974 to May 1987, Petitioner worked for Freeman United Coal at its No. 4 mine. From June 1988 through March 2004, Petitioner worked at American Coal. He then returned to Freeman at its Crown II mine from March 2004 through June 2007. He began employment for

Respondent in June 2007 and worked there until his retirement. Petitioner testified that when he first started working in the mines the dust was really bad. When he sat on the miner he could not see his hand in front of his face from the coal dust. While working at the Eagle Mines, Petitioner ran a shuttle car, roof bolted, and shoveled. Petitioner testified that while working as a roof bolter he would have to load bolts on a roof bolter. He testified that the roof bolts each weighed five pounds and came in bundles of five. He loaded 200 to 500 bolts per day. Petitioner considered that job to be heavy manual labor.

While working at Freeman 4, Petitioner was a laborer, roof bolter, and miner operator. At that time he rock dusted, shoveled on the belt, ran machinery, and hung high voltage cable. He testified he had two or three people help him hang the high voltage cable due to its size. As a miner operator when he was not operating the miner he would hang curtains and do whatever else needed to be done. He testified he also ran a scoop. Petitioner testified that the dust conditions were "super bad" at Freeman 4. At American Coal, Petitioner roof bolted and ran a miner. When he left American Coal his job classification was mine examiner where he walked and inspected the belts daily. As an examiner he would walk no less than five miles a day. He described the ground he was walking on as "ridgy" and up and down. He had to step over things like water pipes and go around rock falls. He testified that the ground was not always dry and a lot of times he would have to go through standing water between an inch deep to over his knees. He testified that examining the long wall face was a pretty dusty job. When he went to work at Crown II mine, he started as outby which included rock dusting, shoveling on the belt, and running the miner. He testified that while they tried to keep the dust down, it was pretty dusty. At Respondent, Petitioner's jobs included rock dusting, shoveling on the belt, hanging cable and curtains, driving ram cars, and running the miner.

Petitioner testified that while doing his job classifications at Respondent he would become short of breath. He did not get down but he had to stop and take five. He testified that they did not push him. He described all his jobs in the coal mines as heavy manual labor. Petitioner testified that his job duties required him to bend, stoop, and squat which caused him some breathing problems. He testified he is also a little heavy which did not help any.

Petitioner testified that as of arbitration he had breathing problems. When he was working at Freeman No. 4 he could tell a difference in his breathing. He testified he became worried at that time about getting out of the mines because of the dust. When he sat on the miner and could not see his hand in front of his face he knew it could not be good for him. He worked at Freeman 4 in the mid-1980s. He noticed shortness of breath while performing manual labor such as shoveling on the belt, hanging the cable, and walking as a examiner. Petitioner testified that if he were to go outside and walk on level ground at a normal pace, he could probably walk around a quarter of a mile before becoming short of breath. He testified he could probably climb a flight and a half of stairs before becoming short of breath. Petitioner testified that from the time he noticed his breathing problems at Freeman 4 until arbitration his breathing has gotten worse. Petitioner testified that he was taking medication for respiratory complaints and also takes a lot of sinus medicine. He testified that his breathing affects his walking and doing work in the yard. He testified he takes frequent breaks. He mows his one and a half acre yard with a small tractor. His wife usually does the weed eating. He testified he is not able to do the yard work today like he was able to do it 15 years ago because of his breathing.

Petitioner testified he hunts deer with a gun and bow and walks about half a mile to get to his deer stand. He takes his time and stops a couple of times before he gets to the stand, which is up in the air. He fishes from a boat. He testified he usually has someone with him when he is fishing to help him back the boat into the water and launch it.

Petitioner testified he treated with his primary care physician, Dr. Clayton Ford at Harrisburg Medical Clinic, for congestion and respiratory infections. Petitioner testified he started smoking cigarettes around 1970 and quit smoking in 1995. Towards the end he smoked close to pack a day.

Petitioner testified that it was fair to say that while working in the mines he completed his job every day but at the end it was getting harder to do. At the time of arbitration, Petitioner testified he could not do any of his former coal mine jobs. He testified he was off work for a little while on disability for his leg after a ram car ran over him. He testified that one of the injuries he sustained in the mines happened when a big rock fell on his head. He could not recall if he was off work on disability until a short time before he retired. He is receiving social security and Medicare. He received a pension from the United Mine Workers for his employment with Freeman. He also had a 401(k) from American Coal which was rolled into his 401(k) plan at Respondent.

While employed at the mine, Petitioner underwent chest x-ray screening for black lung by NIOSH on one occasion. He testified he received a letter with the screening results but did not bring the letter with him to arbitration. Petitioner testified he has an exercise bike which he does not use near enough and it bothers his breathing and knee. He killed a couple of deer this past year and uses a four-wheeler to haul them out of the woods. He testified he has had weight change since he retired. When he was examined by Dr. Istanbouly he weighed 278 pounds and at Methodist Hospital he weighed 271 pounds. As of arbitration he weighed about 285 pounds. Petitioner testified he takes Flomax for his prostate, Pantoprazole for GERD which he stopped in 2020 when he had a hiatal hernia, Atorvastatin for cholesterol, and Duloxetine for anxiety.

MEDICAL HISTORY

On 10/7/16, Dr. Henry K. Smith reviewed a chest x-ray taken on 9/29/16. Dr. Smith is board-certified in radiology and is a NIOSH certified B-Reader. Dr. Smith passed his initial B-Reader examination in 1987 and maintained his certification status continuously over 34 years. Dr. Smith found that the chest film was a quality 1 film and his impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary p, all zones involved bilaterally, of a profusion 1/1.

On 10/2/17, Dr. Cristopher Meyer reviewed a chest x-ray of Petitioner dated 9/29/16. Dr. Meyer is a board-certified radiologist and a NIOSH certified B-reader. Dr. Meyer indicated the film was a quality 2 film, because of improper position, rotated, and scapula overlay. Dr. Meyer's impression was that there were no radiographic findings of coal workers' pneumoconiosis on the film.

On 10/16/17, Petitioner underwent a pulmonary function test at Methodist Hospital ordered by Dr. Jeff Selby. The report states Petitioner was unable to meet standards on the PEF on the Pre FCV and the FEV1 and the post FVC in spite of multiple attempts. Dr. Selby indicated the spirometry and diffusion capacity was normal.

On 8/8/18, Dr. Christopher Meyer testified by way of evidence deposition. Dr. Meyer is a board-certified radiologist who has a B-Reading certificate. Dr. Meyer testified he currently works as the Vice Chair of Finance and Business Development and is a professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin. He testified that he reviewed a PA and lateral chest x-ray of Petitioner dated 9/29/16 from Ferrell Hospital and found it to be a quality 2 film due to improper position, it was rotated, with scapular overlap. Dr. Meyer testified it was his impression there were no radiographic findings of coal workers' pneumoconiosis on the film.

On cross examination, Dr. Meyer agreed that experts with similar credentials may disagree on the reading of chest films, especially those in Category 1 of pneumoconiosis. He agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown they actually had the condition pathologically. Dr. Meyers agreed with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays". Dr. Meyers explained that "[m]ost of the nodules that we see on chest x-rays are known as summation shadows, which means that multiple coal macules superimposed on one another form a shadow that's big enough for us to see."

On 8/24/18, Dr. Istanbouly testified by way of evidence deposition. Dr. Istanbouly testified is board-certified in critical care medicine and pulmonary medicine. He performs black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. He is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and has been the director of the Intensive Care Unit at Herrin Hospital. Dr. Istanbouly examined Petitioner on 5/23/17 and took a detailed history of his employment, the most pertinent being Petitioner's work as a coal miner for 44 years. Dr. Istanbouly noted Petitioner's last month of employment in coal mining was April 2016 and he smoked one pack per day for 20 years. Petitioner had intermittent cough for years and mentioned that brisk walking and strenuous activities were triggering factors for his cough. Petitioner's cough was mild to moderate in intensity and he had exertional dyspnea walking a quarter of a mile.

Dr. Istanbouly reviewed the pulmonary function testing and the chest x-ray. He testified it is not unusual for miners with simple coal worker's pneumoconiosis to be asymptomatic. He testified that a coal miner can have coal worker's pneumoconiosis and not know they have it. On physical examination of Petitioner's chest he found decreased breath sounds evidencing reduced air bilaterally. He related Petitioner's decreased breath sounds to his coal workers' pneumoconiosis. Dr. Istanbouly testified that a person does not have to have abnormalities on

physical examination of the chest and that it is not unusual for someone with early stages of coal workers' pneumoconiosis to have a normal physical examination of the chest.

Dr. Istanbouly testified that Petitioner's pulmonary function studies revealed a moderate nonspecific ventilatory limitation which could be related to a restrictive defect or mixed restrictive and obstructive defect. He could not say if it was truly restrictive as lung volumes were not performed. Dr. Istanbouly testified that the main culprit in Petitioner's moderate ventilatory limitation was his long-term coal dust inhalation, although his smoking history could not be ruled out as a contributing factor. Dr. Istanbouly testified that a person with coal workers' pneumoconiosis could have pulmonary function testing that is completely normal, which is not unusual in the early stages of the disease. He testified that spirometry is a measure of the global impairment of both lungs rather than a focal impairment of a portion of the lungs. He testified that a person could have a certain amount of their lung with focal impairment, yet the global overall function be normal. Dr. Istanbouly testified that a person could even have shortness of breath and daily cough but have a normal pulmonary function test. He also testified that a person could have a normal diffusing capacity and have mild coal workers' pneumoconiosis.

Dr. Istanbouly testified that he personally reviewed Petitioner's chest x-ray which was taken on 9/29/16. He customarily reviews and interprets chest x-rays in providing care and treatment to his patients. He found the chest x-ray to be of diagnostic quality and it revealed mild bilateral interstitial changes consistent with coal workers' pneumoconiosis. Dr. Istanbouly testified he also reviewed a B-reading report of Dr. Smith who reached the same conclusion and described the profusion was 1/1. Dr. Istanbouly testified you do not have to be a B-reader in order to diagnose someone with coal workers' pneumoconiosis. He testified there are no B-readers in any of the hospitals in which he is affiliated, the closest being approximately 100 miles away. Dr. Istanbouly testified he does not rely on a B-reader's interpretation of chest films in diagnosing his patients with coal workers' pneumonoconiosis but relies on his own training and experience.

Dr. Istanbouly testified that coal workers' pneumoconiosis is caused by the inhalation of coal dust that causes irritation and inflammation that ultimately forms tiny scars. He testified that coal worker's pneumoconiosis causes scarring to occur, referred to as fibrosis, and that the scarring and fibrosis are permanent. He testified that the scarring and fibrosis cannot carry on the function of normal healthy lung tissue. Dr. Istanbouly testified that, by definition, if you have coal workers' pneumoconiosis then you have an impairment of the function of the lungs, at least at the site of the scar or fibrosis and that only exposure to coal dust can cause coal workers' pneumoconiosis. Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis.

Dr. Istanbouly testified that, based upon on a reasonable degree of medical certainty, Petitioner's coal workers' pneumoconiosis was caused by his long-term coal dust inhalation. He testified that Petitioner has clinically significant pulmonary impairment based on his cough and exertional dyspnea. He testified that Petitioner also has an environmental impairment in terms of being precluded from safely returning to the environment of the coal mine due to his coal workers' pneumoconiosis. That based on Petitioner's x-ray it is not advisable for Petitioner to ever return to work in the coal mines. Dr. Istanbouly testified that any additional exposure to coal dust would cause the damage to his lungs to worsen. He testified that according to the American

Thoracic Society, there is no safe level of dust exposure for someone who has coal workers' pneumoconiosis. Dr. Istanbouly testified that Petitioner has damage to his lungs as a result of his occupational exposure to coal dust.

On 8/27/18, Dr. David Rosenberg testified by way of evidence deposition. Dr. Rosenberg is board-certified in internal medicine and pulmonary diseases. He obtained a Master's of Public Health and is board-certified in occupational medicine. Dr. Rosenberg became a B-reader in 2000. He is licensed in Ohio, Kentucky, Tennessee, and Florida. Dr. Rosenberg reviewed Petitioner's treatment records from Pinckneyville Hospital, Southern Illinois Medical Care Associates, Orthopedic Institute, CT and Open MRI Center, Harrisburg Medical Center, Dr. DeGrange, Integrated Health, Dr. Smith, Dr. Meyer, Dr. Istanbouly, and Methodist Hospital. He also reviewed a chest x-ray dated 9/29/16 and found the film was a quality 1 and negative for coal workers' pneumoconiosis. Dr. Rosenberg testified that Petitioner did not have any parenchymal changes related to coal dust exposure and pulmonary function and diffusion capacity testing were normal.

Dr. Rosenberg testified that he does 5 or 6 records reviews a week for coal worker's litigation. He testified he has treated 10 to 20 patients for black lung out of one or two thousand patients over his career. Dr. Rosenberg testified that he performed black lung examinations for the Department of Labor from 1979 to 1984. He contracted out his services as a B-reader to industry companies such as General Electric, steel mills, and private occupational medicine services.

Dr. Rosenberg agreed that scarring and fibrosis occur with coal workers' pneumoconiosis which adversely affects lung function. He agreed there is no cure for coal workers' pneumoconiosis and the scarring and fibrosis is permanent. Dr. Rosenberg indicated that coal workers' pneumoconiosis could progress in the absence of further exposure, but it is unusual. He agreed that the best treatment for someone with coal workers' pneumoconiosis is to remove that person from the exposure. He agreed that a person could have coal workers' pneumoconiosis without having chest x-ray evidence of the disease or know that they have the disease. Dr. Rosenberg agreed that a person could have shortness of breath despite normal pulmonary function. He also agreed that a person could have normal pulmonary function and have coal workers' pneumoconiosis, stating that it would not be unusual, and most would have normal pulmonary function. He agreed that a person could have a certain amount of their lungs with focal areas of impairment, yet their global function be normal. Dr. Rosenberg agreed that a person could lose a third of their lung function and have a normal pulmonary function testingHe testified that a person could have a normal diffusing capacity and have simple coal workers' pneumoconiosis.

Dr. Rosenberg did not take a patient history of Petitioner or speak with Petitioner or his examining or treating doctors. Dr. Rosenberg did not perform a physical examination of Petitioner or perform any testing. Dr. Rosenberg testified that the reading of chest x-rays for coal workers' pneumoconiosis is very subjective. He agreed that similarly qualified physicians can and do disagree as to the findings on chest x-rays and that would especially be true in borderline cases of 0/1 or 1/0. Dr. Rosenberg agreed that a physician does not have to be a B-reader to diagnose someone with coal workers' pneumoconiosis and the B-reading system was never

designed for and should not be used for diagnostic purposes. Dr. Rosenberg testified that the only records he reviewed regarding the disease of coal workers' pneumoconiosis were Dr. Istanbouly's report, the pulmonary function report from Methodist Hospital, and the B-readings of Drs. Smith and Myers.

On 2/3/20, Dr. Henry Smith testified by way of evidence deposition. Dr. Smith became board-certified in radiology in 1973 and has been a certified NIOSH B-reader continuously since 1987. Dr. Smith holds medical licensure in five states and is affiliated with or has privileges at numerous hospitals and clinics. Dr. Smith reviewed Petitioner's chest x-ray and found it to be a quality 1 and noted the presence of small opacities, p primary, secondary p, upper, middle, and lower zones bilaterally involved of a profusion of 1/1. Dr. Smith opined that Petitioner has coal worker's pneumoconiosis and has damage to his lungs as a result of his coal worker's pneumoconiosis.

Respondent offered medical records from SIMCA the majority of which consist of traumatic injuries that Petitioner suffered while working in the coal mines. There are many entries of no shortness of breath or dyspnea on exertion. There were no pulmonary examinations, pulmonary function studies, or chest x-rays included in these records. There were several entries of acute respiratory infections.

Respondent entered medical records from Harrisburg Medical Center. The records do not contain chest x-rays, pulmonary function studies, or pulmonary evaluations. The records consist of care and treatment of Petitioner for various illnesses of daily life and follow up visits for his traumatic injuries in the coal mines. The records do state that physical examination of Petitioner's chest is within normal limits and do not contain any entries of shortness of breath or dyspnea on exertion.

CONCLUSIONS OF LAW

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

Issue (F): Is Petitioner's current condition of ill-being casually related to his occupational exposure?

The Arbitrator finds that Petitioner was last exposed to an occupational disease that arose out of and in the course of his employment with Respondent. Section 1(d) of the Illinois Workers' Compensation Diseases Act states, in pertinent part:

> "A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however

> short, he or she is employed in an occupation or process in which the hazard of the disease exists...If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment." 820 ILCS 310/1(d)

On 9/29/16, Petitioner underwent a chest x-ray at Ferrell Hospital. On 10/7/16, Dr. Henry Smith, a board-certified B-Reader for over 32 years, performed a chest film interpretation and B-Reading. Dr. Smith's impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary p, all zones involved bilaterally, of a profusion 1/1. Dr. Istanbouly physically examined Petitioner and took a detailed medical and occupational history. Dr. Istanbouly opined Petitioner had coal workers' pneumoconiosis that was causally related to his long-term exposure to coal mine dust. Dr. Istanbouly's testimony reveals his significant experience and credentials in the field of pulmonary studies. He is board-certified in critical care medicine and pulmonary medicine.

The Arbitrator finds the opinions of Drs. Smith and Istanbouly more persuasive than those of Drs. Meyer and Rosenberg. Although they disagree as to the diagnostic findings and diagnosis of pneumoconiosis, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown that they had the condition pathologically. Dr. Meyers agreed that individual coal macules are generally too small to be appreciated on chest x-rays. Dr. Meyer found Petitioner's chest x-ray to be a quality 2 due to improper position, rotation, and scapular overlay, while Dr. Rosenberg found it to be a quality 1 and did not see any of the imperfections that Dr. Meyer found.

Dr. Rosenberg had never met, spoken to, or physically examined Petitioner. Dr. Rosenberg testified that 95% of his black lung examinations are for industry. He agreed that a person could have coal workers' pneumoconiosis without having chest x-ray evidence of the disease. He also agreed that a person can have coal workers' pneumoconiosis and not know that they have the disease. Dr. Rosenberg agreed that a person could have shortness of breath despite normal pulmonary function. He also agreed that a person could have normal pulmonary function and have coal workers' pneumoconiosis, stating it would not be unusual and most would have normal pulmonary function. He agreed that a person could have a certain amount of their lungs with focal areas of impairment, yet their global function be normal. He testified that a person could have a normal diffusing capacity and have simple coal workers' pneumoconiosis.

Given the totality of the evidence, the Arbitrator finds Petitioner has satisfied the requirements of Section (d) of the Act and that Petitioner's coal workers' pneumoconiosis arose out of and in the course of his employment with Respondent. The Arbitrator further finds that Petitioner's condition of ill-being is causally connected to this exposure.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of

impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner retired from his employment with Respondent on 4/4/16 and has not sought employment since. The Arbitrator gives some weight to this factor.

(iii) **Age**: Petitioner was 65 years old at the time of his last exposure. Petitioner is retired. The Arbitrator places some weight on this factor.

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity contained in the record and Petitioner retired on 4/4/16. The Arbitrator places some weight on this factor.

(v) **Disability**: As a result of his work exposure, Petitioner testified he continues to have breathing problems. He can walk on level ground at a normal pace for approximately a quarter of a mile before becoming short of breath. He testified he could probably climb a flight and a half of stairs before becoming short of breath. He testified his condition has gotten worse and his breathing affects his walking and yard work. He takes frequent breaks but continues to engage in his hobbies. The Arbitrator places greater weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator orders Respondent to pay Petitioner the sum of $**755.22 (Max. rate)**/week for a period of **25 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused **5% loss of the body as a whole.**

Issue (O): Sections 1(d)-(f) of the Occupational Diseases Act.

Section 1(e) of the Occupational Diseases Act states, in pertinent part, "{d}isablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e). The Arbitrator finds Petitioner has satisfied the requirements of Section (e) of the Act. Petitioner testified to increased respiratory difficulty with his activities of daily living, like walking and climbing stairs. Dr. Istanbouly also testified that the inhalation of coal dust that causes irritation and inflammation will ultimately form tiny scars. Dr. Istanbouly testified there is no cure for coal workers' pneumoconiosis and the condition is chronic. Dr. Rosenberg agreed that the scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. Dr. Rosenberg testified that the scarring and fibrosis is an alteration of the lung tissue.

Section 1(f) of the Occupational Diseases Act states, in pertinent part, "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f). Petitioner last worked a day of coal mine employment on April 4, 2016. Petitioner has not worked in the coal mines and has not had any other exposure to coal

mine dust since that date. On 9/29/16, Petitioner underwent a chest x-ray with PA & Lateral views that revealed simple pneumoconiosis, category p/p, 1/1. Petitioner was diagnosed with coal workers' pneumoconiosis within two years of leaving Respondent's employment and therefore meets the requirement under Section 1(f) of the Act.

Based on the totality of the evidence, and the factual findings above, the Arbitrator finds that Petitioner met the requirements of Sections 1(d)-(f) of the Occupational Diseases Act.

Arbitrator Linda J. Cantrell

DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC016174
Case Name	WEBB, CHRISTINA v. STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0151
Number of Pages of Decision	11
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Richard Salmi
Respondent Attorney	Cori Stewart

DATE FILED: 4/21/2022

/s/ Deborah Simpson, Commissioner

Signature

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

Christina Webb,
Petitioner,

vs. NO: 16 WC 16174

IDOT,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 22, 2021, 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.

April 21, 2022

o4/13/22
DLS/rm
046

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

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC016174
Case Name	WEBB, CHRISTINA v. IDOT
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	9
Decision Issued By	William Gallagher, Arbitrator

Petitioner Attorney	Richard Salmi
Respondent Attorney	Cori Stewart

DATE FILED: 10/22/2021

THE INTEREST RATE FOR THE WEEK OF OCTOBER 19, 2021 0.06%

/s/ William Gallagher, Arbitrator
Signature

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

October 22, 2021

/s/ Brendon O'Rourke
Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Christina Webb
Employee/Petitioner

v.

IDOT
Employer/Respondent

Case # 16 WC 16174

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on September 21, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On March 23, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $77,762.70; the average weekly wage was $1,556.00.

On the date of accident, Petitioner was 52 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $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 as identified in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $1,037.33 per week for three and six-sevenths (3 6/7), commencing August 10, 2016, through September 5, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $755.22 per week for 50 weeks, because the injury sustained caused the 10% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator **OCTOBER 22, 2021**

ICArbDec p. 2

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on March 23, 2016. According to the Application, Petitioner was "Holding and moving signs in heavy winds" and sustained an injury to her "Left shoulder and BAW" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship. In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits of three and six-sevenths (3 6/7) weeks, commencing August 10, 2016, through September 5, 2016. Respondent stipulated Petitioner was disabled during the aforestated period of time, but disputed liability for same (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a highway maintainer. Petitioner's job duties included setting up traffic control on highways, flagging, filling potholes, removing dead animals, plowing snow, cutting trees and other assigned tasks.

The basis of Petitioner's claim was that she was required to hold a traffic control sign on a seven foot pole while she was in the process of "flagging" traffic. Petitioner testified the "flag" at the top of the pole was 24 inches wide. Petitioner said holding the pole/flag when it was windy could be extremely difficult and challenging. Petitioner usually held the pole with her left hand, but when conditions were windy, she would hold the pole with both hands. When conditions were windy, Petitioner would place one of her hands just below the base of the "flag." Petitioner described the situation as being "fighting" the wind.

In February, 2016, Petitioner began to experience left shoulder pain. On March 23, 2016 (the date of accident alleged in the Application) Petitioner's left shoulder pain became unbearable. Petitioner reported the symptoms to her supervisor that same day and was directed to seek medical treatment at the VA.

Petitioner was initially seen at the VA for left shoulder symptoms on March 24, 2016. Petitioner attributed her left shoulder symptoms to holding a sign at work (Petitioner's Exhibit 6; p 85).

Petitioner received physical therapy at the VA. On April 20, 2016, it was recommended Petitioner undergo an orthopedic consultation because of possible left rotator cuff pathology. On April 26, 2016, it was noted Petitioner had some improvement after physical therapy, but she still lacked a full range of motion and was on light duty at work (Petitioner's Exhibit 6; pp 72, 87).

On June 1, 2016, Petitioner was evaluated by Dr. Nathan Mall, an orthopedic surgeon. At that time, Petitioner informed him she had left shoulder pain which she attributed to using stop-and-go paddles at work for several days in a row. Dr. Mall diagnosed Petitioner with left shoulder rotator cuff tendinitis and left shoulder joint arthrosis. He administered an injection into the subacromial space and recommended Petitioner continued physical therapy. He also recommended Petitioner undergo an MRI scan. Further, Dr. Mall opined Petitioner's work activities could cause rotator cuff tendinitis (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. Aaron Omotola, an orthopedic surgeon, on June 3, 2016. Petitioner complained of left shoulder pain since March, 2016, and advised that she was required to hold traffic paddles at work. Dr. Omotola ordered further physical therapy and an MRI scan (Petitioner's Exhibit 3).

The MRI was performed on June 28, 2016. According to the radiologist, the MRI revealed a full thickness tear of the supraspinatus tendon and mild acromioclavicular joint degenerative changes (Petitioner's Exhibit 3).

Dr. Omotola performed surgery on Petitioner's left shoulder on August 10, 2016. The procedure consisted of a double-row rotator cuff repair, subacromial decompression, distal clavicle excision and biceps tenodesis (Petitioner's Exhibit 3).

Following surgery, Petitioner continued to be treated by Dr. Omotola who ordered physical therapy. Dr. Omotola released Petitioner to return to work with a 30 pound lifting restriction on March 10, 2017. He subsequently authorized Petitioner to return to work at full duty effective April 1, 2017 (Petitioner's Exhibit 3).

At the request of her attorney, Petitioner was examined by Dr. Corey Solman, an orthopedic surgeon, on August 17, 2018. In connection with his examination of Petitioner, Dr. Solman reviewed medical records provided to him by her attorney. When evaluated by Dr. Solman, Petitioner advised him that in February and March, 2016, she was working outside holding a seven foot flagging pole during windy weather. Petitioner stated she developed left shoulder pain as a result of performing those duties and it had progressed to the point to where she could no longer tolerate it and on March 23, 2016, she reported her increasing left shoulder symptoms to her employer (Petitioner's Exhibit 1; Deposition Exhibit 2).

Dr. Solman noted Petitioner had a previous shoulder strain several years prior, but did not experience any issues with it thereafter. Dr. Solman opined Petitioner's work-related duties leading up to March 23, 2016, were a substantial contributing factor to the development of her left shoulder pathology, namely, the left shoulder rotator cuff tear which was treated by Dr. Omotola. Dr. Solman also opined there were no “other outside activities or incidences” that could have caused the rotator cuff tear (Petitioner's Exhibit 1; Deposition Exhibit 2).

Dr. Solman was deposed on October 27, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Solman's testimony was consistent with his medical record and he reaffirmed the opinions contained therein. In regard to causality, Dr. Solman testified Petitioner's attempting to stabilize the poles/signs during windy conditions placed a stress on the shoulder. Over time, with this type of forceful activity, shoulder pathology can occur (Petitioner's Exhibit 1; p 21).

On cross-examination, Dr. Solman testified he did not know of any other contributing factors of Petitioner's left shoulder condition. He agreed Petitioner had a "great outcome," but needed to be careful when performing activities which caused her to experience pain (Petitioner's Exhibit 1; pp 25-26).

On redirect examination, Dr. Solman explained that the surgery was a repair of soft tissue which had been torn away from bone. Because of this, there would always be an increased risk of tearing and pain symptoms with vigorous activities (Petitioner's Exhibit 1; pp 27-28).

At the direction of Respondent, Petitioner was examined by Dr. Michael Nogalski, an orthopedic surgeon, on December 9, 2019. In connection with his examination of Petitioner, Dr. Nogalski reviewed medical records and diagnostic studies provided to him by Respondent. At that time, Petitioner informed Dr. Nogalski of her flagging during February and March, 2016. Petitioner advised him she had to control the signs with her arms which was difficult because they would get blown around by the wind. Petitioner did not describe a specific event, but stated the shoulder symptoms came on gradually. Dr. Nogalski asked Petitioner about her prior left shoulder problem from 2009, and Petitioner did not recall the specific problem, but that she had a resolution of her symptoms (Respondent's Exhibit 1).

Petitioner advised she experienced some general fatigue in the left shoulder and occasional aches after longer days at work. However, Petitioner acknowledged she had returned to work without restrictions. Dr. Nogalski's findings on examination of Petitioner's left shoulder were normal as was the range of motion of the left shoulder (Respondent's Exhibit 1).

In his review of Petitioner's medical records, Dr. Nogalski noted x-rays were taken on April 1, 2009, of Petitioner's left shoulder which revealed some irregularities in the greater tuberosity of the left shoulder. He also noted Petitioner had complaints of left shoulder pain on March 8, 2011, after she had performed manual labor, but the examination of the left shoulder on that date was normal (Respondent's Exhibit 1).

In regard to causality, Dr. Nogalski opined there was not a causal relationship between Petitioner's left shoulder condition and her work activities. He noted there was not a singular injury and no specific task placed her at risk for rotator cuff tendinitis. Dr. Nogalski references the cystic changes in the greater tuberosity region observed in 2009 and this was supportive of long-standing pre-existing rotator cuff disease. He also opined the medical treatment Petitioner had received to date was reasonable and necessary (Respondent's Exhibit 1).

Dr. Nogalski was deposed on May 11, 2020, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Nogalski's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Nogalski testified the cause of Petitioner's left shoulder condition was her long-standing rotator cuff tendon disease which ultimately resulted in loss of the normal rotator cuff insertion in the greater tuberosity region. He stated this would cause intermittent symptoms especially if Petitioner was doing job duties which required her to lift heavier objects or move her shoulder in ways that caused greater stress on it (Respondent's Exhibit 2; pp 16-17).

On cross-examination, Dr. Nogalski agreed rotator cuff tendinopathy, lateral compression and degenerative changes of the rotator cuff can be asymptomatic. He also agreed that there were movements of the shoulder which could cause a rotator cuff tear and movements which could cause degenerative changes to become symptomatic (Respondent's Exhibit 2; p 22).

At trial, Petitioner testified she has less strength and stamina in regard to her left shoulder. Specifically, when Petitioner is shoveling cold patch, she can no longer pick up a full shovel. When Petitioner is flagging, she now has to switch hands more frequently. Further, Petitioner now asks for co-workers to assist her when performing certain tasks. Petitioner said that using saws and the weed eater is now more difficult because of their weight and the fact she has to switch hands because her left shoulder cannot stay elevated for as long as it did previously. Petitioner testified that, by the end of the work day, her left shoulder aches and she takes Tylenol on a regular basis.

On cross-examination, Petitioner agreed she was able to return to work to the same position she had at the time she sustained the injury. Petitioner also acknowledged that she does not have any permanent work restrictions and does not take any prescribed medication.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent which manifested itself on March 23, 2016, and her current condition of ill-being in regard to her left shoulder is causally related to her work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified that she was required to perform flagging duties which consisted of holding a seven foot pole with a sign which was extremely difficult during windy conditions. During February and March, 2016, she began to experience left shoulder symptoms which got progressively worse.

On March 23, 2016, Petitioner's left shoulder symptoms became unbearable and she reported them to her supervisor.

Petitioner provided a consistent history of her job duties and the onset of her left shoulder symptoms to all of the medical providers who treated and examined her.

Dr. Mall opined Petitioner's work activities could cause rotator cuff tendinitis.

Petitioner's Section 12 examiner, Dr. Solman, opined Petitioner's work duties were a substantial contributing factor to the development of Petitioner's left shoulder pathology. This was based, in part, on the fact that Petitioner's attempting to stabilize the poles/signs during windy conditions placed stress on the left shoulder and, over time, caused left shoulder pathology. Further, Dr. Solman was aware Petitioner had a prior left shoulder strain, but Petitioner did not experience any issues with it afterward.

Respondent's Section 12 examiner, Dr. Nogalski, opined Petitioner's left shoulder condition was not related to her work activities, but was because of long-standing rotator cuff tendon disease. This was based, in part, on x-rays taken in 2009, which revealed cystic changes in the greater

tuberosity. However, Dr. Nogalski agreed certain movements of the shoulder could cause a rotator cuff tear and cause degenerative changes to become symptomatic.

Based on the preceding, the Arbitrator finds the opinions of Dr. Mall and Dr. Solman in respect to causality to be more persuasive than that of Dr. Nogalski.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

There was no dispute regarding the reasonableness and necessity of the medical services provided to Petitioner.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of three and six-sevenths (3 6/7) weeks, commencing August 10, 2016, through September 5, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner and Respondent stipulated Petitioner was temporarily totally disabled during the aforestated period of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

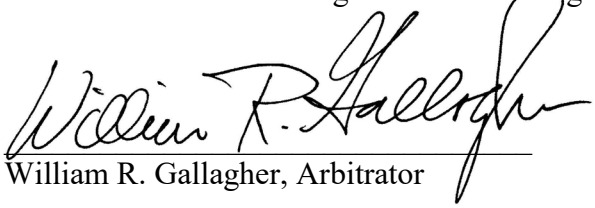
Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked for Respondent as a highway maintainer at the time she sustained the injury and was able to return to work to that job without restrictions. However, the Arbitrator notes that this is a physically demanding job and Petitioner continues to experience left shoulder symptoms while performing certain job tasks, some of which require her to ask co-workers for assistance. The Arbitrator gives this factor moderate weight.

Petitioner was 52 years old at the time she sustained the accident and 58 years and at the time of trial. Petitioner will have to live with the effects of the injury for the remainder of her working and natural life. The Arbitrator gives this factor moderate weight.

Petitioner returned to the same job she had at the time she sustained the accident. There was no evidence of Petitioner having a reduced earning capacity because of the injury. The Arbitrator gives this factor moderate weight.

Petitioner sustained a left shoulder injury as a result of the accident which required surgery consisting of a double-row rotator cuff repair, subacromial decompression, distal clavicle resection and biceps tenodesis. Petitioner had a good surgical result and was able to return to work to her regular job; however, Petitioner continues to have complaints consistent with the injury she sustained. The Arbitrator gives this factor significant weight.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC024030
Case Name	REEL, MIKE v. PRAIRIE STATE GENERATING CO
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0152
Number of Pages of Decision	13
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Thomas Crosby
Respondent Attorney	Michael Karr

DATE FILED: 4/21/2022

/s/ Deborah Simpson, Commissioner

Signature

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

Mike Reel,

Petitioner,

vs. NO: 16 WC 24030

Prairie State Generating Co.,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 20, 2021, 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 21, 2022

o4/13/22
DLS/rm
046

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

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC024030
Case Name	REEL, MIKE v. PRAIRIE STATE GENERATING COMPANY LLC
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	10
Decision Issued By	William Gallagher, Arbitrator

Petitioner Attorney	Thomas Crosby
Respondent Attorney	Michael Karr

DATE FILED: 9/20/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 14, 2021 0.05%

/s/William Gallagher, Arbitrator

Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mike Reel
Employee/Petitioner

Case # 16 WC 24030

v.

Consolidated cases: n/a

Prairie State Generating Company, 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 city of Herrin, on August 16, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, June 2, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $42,361.22; the average weekly wage was $1,176.70.

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

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

Respondent shall be given a credit of $319,197.63 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $319,197.63. The parties stipulated TTD benefits were paid in full to the date of trial.

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

ORDER

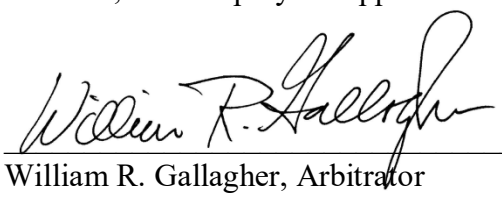
Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 3, 5, 7, 9, 11, 16, 18, 20, 22, and 24, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the cervical foraminotomy as recommended by Dr. Matthew Gornet.

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

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

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



SEPTEMBER 20, 2021

William R. Gallagher, Arbitrator
ICArbDec19(b)

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 June 2, 2015. According to the Application, Petitioner was "Standing up a man door" and sustained an injury to the "Neck and Back" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Petitioner and Respondent stipulated Petitioner sustained a work-related accident on June 2, 2015, and Respondent had paid Petitioner temporary total disability benefits amounting to $319,197.63 and was continuing to make payment of same. The prospective medical treatment sought by Petitioner was a cervical foraminotomy as recommended by Dr. Matthew Gornet, an orthopedic surgeon. Respondent disputed liability for the prospective medical treatment sought by Petitioner on the basis of medical causality as well as the reasonableness and necessity of the treatment recommended by Dr. Gornet. Respondent's position was based on the opinion of its Section 12 examiner, Dr. Daniel Kitchens, a neurosurgeon (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a coal miner. On June 2, 2015, Petitioner was in the process of standing up a man door which weighed approximately 100 pounds. The lip of the door was stuck on lids of buckets of sealant on which it was stacked. Petitioner attempted to get the door loose by pulling on the door in an effort to free it. When he did so, Petitioner experienced a sharp pain in his neck and low back.

Following the accident, Petitioner was treated at Sparta Community Hospital where he was initially evaluated on June 5, 2015. At that time, Petitioner complained of low back pain and Petitioner received physical therapy at Sparta Community Hospital for approximately three months (Petitioner's Exhibit 21).

At the direction of Respondent, Petitioner was examined by Dr. Donald deGrange, an orthopedic surgeon. The initial report of Dr. deGrange was not tendered into evidence at trial; however, Dr. deGrange ordered an MRI scan of Petitioner's lumbar spine.

The MRI was performed on September 12, 2015. According to the radiologist, the MRI revealed an annular tear and paracentral disc extrusion at L3-L4 as well as disc bulges and foraminal stenosis at L4-L5 and L5-S1 (Petitioner's Exhibit 21).

When Dr. deGrange evaluated Petitioner on November 12, 2015, he noted Petitioner continued to have left thigh symptoms as well as neck and left upper extremity pain. Dr. deGrange ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 4).

The MRI was performed on November 12, 2015. According to the radiologist, the MRI revealed degeneration at C3-C4 and C4-C5, disc disease at C5-C6 and foraminal stenosis at C3-C4 and C5-C6. Dr. deGrange also noted that the MRI revealed a disc herniation at C5-C6 (Petitioner's Exhibits 4 and 15).

Dr. deGrange performed surgery on Petitioner's lumbar spine on November 30, 2015. The procedure consisted of a decompression and laminectomy at L3-L4 (Petitioner's Exhibit 12). Subsequent to the lumbar surgery, Dr. deGrange ordered physical therapy. During physical therapy, Petitioner continued to complain of low back and left leg pain as well as neck and left arm/shoulder pain (Petitioner's Exhibit 19).

In the physical therapy record of January 26, 2016, it was noted that, over the weekend, Petitioner had set up shelves, took down doors and was building a closet. In the physical therapy record of February 4, 2016, it was noted Petitioner had been helping his daughter do some work in her house and was sore after performing lifting activities. In the physical therapy record of February 16, 2016, it was noted Petitioner had put up track lighting and used a ladder and chainsaw and after driving for two hours, experienced an increase of his pain symptoms (Petitioner's Exhibit 19). At trial, Petitioner denied having performed any overhead work and said that, while at his daughter's house, he gave her directions on what to do.

Petitioner was again seen by Dr. deGrange on January 20, 2016. At that time, Dr. deGrange noted Petitioner's low back symptoms had improved; however, he reaffirmed his diagnosis of a herniated disc at C5-C6 with spinal stenosis and ordered an epidural steroid injection at C4-C5. When Dr. deGrange saw Petitioner on February 17, 2016, he opined that because of the herniation at C5-C6 and spinal stenosis at C4-C5, Petitioner would require fusion surgery at both levels (Petitioner's Exhibit 4).

On July 11, 2016, Dr. deGrange performed surgery on Petitioner's cervical spine. The procedure consisted of a discectomy and fusion with metal hardware at C5-C6 (Petitioner's Exhibit 12). Dr. deGrange did not perform surgery at C4-C5.

Following surgery, Petitioner continued to be treated by Dr. deGrange who ordered physical therapy and pain management. Petitioner continued to be seen by Dr. deGrange through February 8, 2017. At that time, Dr. deGrange opined Petitioner was at MMI and discharged him from care. However, because of Petitioner having undergone both lumbar and cervical disc surgeries, Dr. deGrange imposed permanent work/activity restrictions (Petitioner's Exhibit 4).

Petitioner was again seen by Dr. deGrange on September 13, 2017. At that time, Petitioner complained primarily of low back and left hip/SI joint pain. Dr. deGrange ordered an MRI scan of Petitioner's lumbar spine (Petitioner's Exhibit 4).

The MRI was performed on October 25, 2017. According to the radiologist, the MRI revealed a herniation at L4-L5, foraminal herniations at L3-L4 and L5-S1 and a disc bulge at L2-L3 (Petitioner's Exhibit 10).

Dr. deGrange evaluated Petitioner on November 29, 2017, and reviewed the MRI findings. Dr. deGrange did not advise any further low back surgery, in particular, a three level fusion. Dr. deGrange recommended further pain management (Petitioner's Exhibit 4).

Petitioner received an extensive amount of pain management treatment in 2018 and 2019. The primary treating physician was Dr. Paul Juergens. Dr. Juergens treated Petitioner for both lumbar and cervical spine complaints, but most of his treatment he provided was for Petitioner's lumbar spine symptoms. Eventually, Dr. Juergens referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 8).

Dr. Gornet initially evaluated Petitioner on October 24, 2019. At that time, Dr. Gornet reviewed medical records and diagnostic studies which included the prior MRI scans. When examined by Dr. Gornet, Petitioner complained of neck pain, primarily on the left side involving the left trapezius, scapula and left arm. Petitioner also complained of low back pain on the left side including the left buttock, hip and down the left leg. Petitioner informed Dr. Gornet the neck pain was worse than the low back pain (Petitioner's Exhibit 1).

Dr. Gornet reviewed prior MRI scans of both the lumbar and cervical spine. In regard to the cervical spine, he noted the MRI of November 12, 2015, revealed disc pathology at C4-C5 and C5-C6. He also opined the fusion at C5-C6 was solid, but it could be putting more stress on the C4-C5 level. Dr. Gornet ordered another MRI scan as well as a CT scan (Petitioner's Exhibit 1).

The MRI and CT scan were performed on October 24, 2019. According to the radiologist, the MRI revealed annular tears and protrusions at C4-C5 and the fusion at C5-C6. There were also other findings at C3-C4 and C6-C7. According to the radiologist, the CT scan revealed the fusion at C5-C6 and arthropathy at C3-C4 and C4-C5 with a small protrusion at C4-C5 (Petitioner's Exhibit 6).

Dr. Gornet reviewed the diagnostic studies and his interpretation of them was consistent with that of the radiologist. Dr. Gornet recommended Petitioner undergo a posterior foraminotomy on the left side, but if this failed, disc replacements at C3-C4, C4-C5 and C6-C7 might be required. He ordered nerve conduction studies to be performed to check for C5 radiculopathy in Petitioner's upper extremity and L4-L5 radiculopathy in Petitioner's lower extremities (Petitioner's Exhibit 1).

Dr. Gornet again saw Petitioner on December 30, 2020. At that time, he renewed his surgical recommendation that Petitioner undergo nerve conduction studies on the upper and lower extremities (Petitioner's Exhibit 6).

Petitioner was evaluated by Dr. Dan Phillips, a neurologist, on March 18, 2020. The nerve conduction studies on Petitioner's upper extremity were positive for mild chronic left C5 radiculopathy. The nerve conduction studies on Petitioner's lower extremities were positive for mild left chronic L3-L4 radiculopathy and milder chronic changes on the right at L3-L4 (Petitioner's Exhibit 14).

At the direction of Respondent, Petitioner was examined by Dr. Daniel Kitchens, a neurosurgeon, on February 4, 2020. In connection with his examination of Petitioner, Dr. Kitchens reviewed medical records and diagnostic studies provided to him by Respondent. In regard to causality, Dr. Kitchens opined the work-related accident caused the disc herniations at C5-C6 and L3-L4. However, he opined that the work accident did not cause, aggravate or exacerbate the foraminal stenosis and cervical spondylosis at C4-C5. Dr. Kitchens also opined the surgery recommended by Dr. Gornet was not medically necessary (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Gornet saw Petitioner on May 18, 2020. He noted the nerve conduction studies revealed C5 radiculopathy and this was consistent with his diagnosis and correlated with Petitioner's neck pain, radiculopathy and foraminal narrowing at C4-C5. Dr. Gornet also reviewed Dr. Kitchens' report and he noted Dr. Kitchens did not address the fact that Dr. deGrange had noted in his report of February 17, 2016, that Petitioner would require cervical disc surgery and a fusion at both C4-C5 and C5-C6. He also noted that medical literature supported adjacent structural pathology secondary to fusion. Dr. Gornet observed Petitioner had C5 radiculopathy revealed by the diagnostic studies which clearly indicated Petitioner had an ongoing problem (Petitioner's Exhibit 6).

At the direction of Respondent, Dr. Kitchens reviewed the nerve conduction studies performed by Dr. Phillips and Dr. Gornet's record of May 18, 2020, and prepared a supplemental report dated August 20, 2020. Dr. Kitchens opined the preceding did not change his opinion regarding causality. He also noted Dr. Gornet had misrepresented the medical literature that adjacent level structural pathology is secondary to fusion because it implied causality, and the medical literature only showed a correlation (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Gornet was deposed on February 21, 2021, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, Dr. Gornet testified that a cervical fusion provides stability, but eliminates motion. He explained that as a result of the stresses and restrictions on movement this can result in pathology in adjoining disc spaces. When questioned about Dr. Kitchens' opinions, Dr. Gornet noted there was disc pathology present at both C4-C5 and C5-C6 from the very beginning and Dr. deGrange contemplated performing fusion surgery at both levels. Dr. Gornet could not say why Dr. deGrange only performed surgery on one level. Dr. Gornet also testified that his findings on clinical examination and the nerve conduction study finding C5 radiculopathy confirm Petitioner had ongoing cervical spine symptoms (Petitioner's Exhibit 26; pp 1031-1046).

In regard to his treatment recommendation, Dr. Gornet explained that the posterior foraminotomy could substantially improve Petitioner's radiculopathy. Dr. Gornet hoped that this procedure would relieve Petitioner's neck symptoms, but if Petitioner continued to have neck pain, even if the radicular symptoms resolved, disc replacement surgeries at C3-C4, C4-C5 and C6-C7 would be appropriate (Petitioner's Exhibit 26; pp 1041-1042).

When Dr. Gornet was questioned about Dr. Kitchens' opinions, he noted that Dr. Kitchens had omitted multiple things in his report. As previously noted herein, Dr. Kitchens did not mention that Dr. deGrange had recommended fusion surgery at both C4-C5 and C5-C6. Further, Dr. Gornet noted Dr. Kitchens failed to reference that Petitioner had structural problems and foraminal stenosis as revealed by the diagnostic studies at C4-C5 (Petitioner's Exhibit 26; pp 1043-1044).

On cross-examination, Dr. Gornet agreed Dr. deGrange initially recommended fusion surgery at both C4-C5 and C5-C6, but only performed a single fusion. He said he did not know why Dr. deGrange only performed surgery at one level. Dr. Gornet provided additional explanations of how a fusion at one level causes stress on adjacent levels. He testified that once a level is fused, the

pressure on the adjacent disc is increased 150 to 300% to where it could cause adjacent level failure (Petitioner's Exhibit 26; pp 1053-1054).

Dr. Kitchens was deposed on March 10, 2021, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Kitchens' testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Kitchens testified the work accident caused the disc herniations at L3-L4 and C5-C6, but did not cause, aggravate or exacerbate the disc disease in the lumbar and cervical spines and did not cause or exacerbate the foraminal stenosis and spondylosis at C4-C5. He described the condition at C5-C6 as being an acute condition and the condition at C4-C5 as being a chronic condition. He also stated he disagreed with Dr. deGrange's recommendation of Petitioner undergoing a fusion at both C4-C5 and C5-C6 (Respondent's Exhibit 1; pp 16-17).

In regard to a fused level putting pressure on either of the adjacent levels, Dr. Kitchens testified there was no scientific evidence supporting this theory and, in the cervical spine, there were only a few degrees of motion anyway. When asked if a level above a fusion was already diagnosed with foraminal stenosis, fusing an adjacent level would not accelerate our increase the degenerative changes because there was no proof (Respondent's Exhibit 1; pp 20-21).

In regard to the foraminotomy surgery recommended by Dr. Gornet, Dr. Kitchens testified the procedure was not necessitated by the work injury. He also said it was not medically necessary because one surgery would not improve Petitioner's condition (Respondent's Exhibit 1; pp 31-32).

At trial, Petitioner testified he continues to have significant symptoms in his neck and low back, but primarily in his neck. Petitioner described neck pain with tingling going into his left shoulder/arm progressing down into the first three fingers of his left hand. Petitioner also said he had a "knot" on the left side of his lower neck which causes him to experience sharp pain. Petitioner wants to proceed with the surgery as recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of June 2, 2015.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident on June 2, 2015.

Petitioner's testimony regarding his ongoing neck and left upper extremity symptoms was credible and unrebutted.

As noted in some entries contained in the physical therapy records of January/February, 2016, Petitioner may have participated in activities which caused him to experience an increase in his

symptoms; however, there was no evidence that these activities amounted to an independent intervening cause.

Dr. deGrange initially evaluated Petitioner as Respondent's Section 12 examiner, but subsequently provided treatment to Petitioner including fusion surgery at C5-C6.

Dr. deGrange initially recommended fusion surgery at both C4-C5 and C5-C6, but only performed fusion surgery at C5-C6. Dr. deGrange's reasons for only performing a one level fusion are unknown.

At no time did Dr. deGrange opine that the disc pathology at both C4-C5 and C5-C6 was not related to the accident of June 2, 2015.

Dr. Gornet has opined that the loss of motion of the fused C5-C6 level causes additional stress on adjacent levels of the spine including C4-C5. Dr. Gornet stated the additional stress can be significant enough to cause adjacent level failure.

Respondent's Section 12 examiner, Dr. Kitchens, opined the work injury caused the acute disc herniation at C5-C6, but did not cause, aggravate or exacerbate the foraminal stenosis and spondylosis at C4-C5. His disagreement with Dr. Gornet's statement about a fused level causing additional stress to adjacent levels seemed to be based on his opinion that there is no proof, but only a correlation.

Based on the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Kitchens in regard to causality.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 3, 5, 7, 9, 11, 16, 18, 20, 22 and 24, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the cervical foraminotomy surgery recommended by Dr. Matthew Gornet.

In support of this conclusion the Arbitrator notes the following:

As noted in disputed issue (F) the Arbitrator found the opinion of Dr. Gornet to be more persuasive than that of Dr. Kitchens in regard to causality.

Dr. Gornet has opined the foraminotomy surgery may provide Petitioner with a significant relief of his neck pain radiculopathy, but if it does not, disc replacement surgery at C3-C4, C4-C5 and C6-C7 may be appropriate.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC019115
Case Name	LIRA, MARTHA v. COOK COUNTY CLERK'S OFFICE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0153
Number of Pages of Decision	13
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Brian McManus, Jr.
Respondent Attorney	Dana Brisbon

DATE FILED: 4/21/2022

/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

Martha Lira,

Petitioner,

vs. No. 20 WC 19115

Cook County Clerk's Office,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary disability, permanent disability, penalties and attorney fees, and being advised of the facts and law, expands, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In affirming the finding of accident on August 3, 2020, the Commission notes consistent histories in the medical records and the section 12 report. In her testimony, Petitioner described the accident as follows: "I entered the ladies room, and when I was going to exit the toilet, I slipped and fell. Afterwards I noticed that there was some water on the floor." Emergency room records from Northwestern Memorial Hospital contain the following description of accident: "[The patient] presents to ED c/o low back pain. She was at work when she slipped on some water and landed on her low back." Follow-up medical records from MacNeal Family Medical Center dated August 6, 2020, note the following history: "[P]atient *** is here for fall on back – slipped on water [at work] about 3 days ago." On October 13, 2020, Dr. Colman, a spine surgeon, noted the following history: "The patient *** was injured on 08/03/2020 when she fell backwards in a bathroom stall after slipping on water on the floor." Lastly, in a section 12 report dated February 16, 2021, Dr. Patel, an orthopedic surgeon, noted "a fall at work on August 3, 2020. She reports walking out of the toilet and subsequently fell onto her back, with immediate back pain."

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 15, 2021, is hereby expanded, affirmed and adopted.

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

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

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

April 21, 2022
SJM/sk
o-03/30/2022
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

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

/s/ *Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC019115
Case Name	LIRA, MARTHA v. COOK COUNTY CLERKS OFFICE
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	10
Decision Issued By	Rachael Sinnen, Arbitrator

Petitioner Attorney	Brian McManus, Jr.
Respondent Attorney	Dana Brisbon

DATE FILED: 10/15/2021

THE INTEREST RATE FOR THE WEEK OF OCTOBER 13, 2021 0.05%

/s/ Rachael Sinnen, Arbitrator

Signature

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

MARTHA LIRA
Employee/Petitioner

v.

COOK COUNTY CLERKS OFFICE
Employer/Respondent

Case # **20** WC **19115**

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 **Arbitrator Rachael Sinnen**, Arbitrator of the Commission, in the city of **Chicago**, on **July 22, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 3, 2020**, 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 $**1,191.20**; the average weekly wage was **$61,912.53**
On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent children.

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

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

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

Respondent is entitled to a credit of **TBD by agreement of the parties** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $22,316.75 (as contained in Petitioner's Exhibit 5), as provided in Sections 8(a) and 8.2 of the Act. By agreement of the parties, Respondent shall be given a credit for bills paid through its group insurance.

Respondent shall pay Petitioner temporary total disability benefits of $794.13/week for 45 1/7 weeks, commencing 8-4-20 through 6-15-21, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $714.72/week for 30 weeks, because the injuries sustained caused the 6% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

No penalties or fees shall be imposed upon Respondent under Sections 19(k), 19(l) and 16 of the Act.

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

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

Signature of Arbitrator

OCTOBER 15, 2021

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

Martha Lira, Petitioner,	)	
v.	)	
	)	Case No. 20 WC 19115
Cook County Clerks Office, Respondent.	)	

FINDINGS OF FACT

This matter proceeded to hearing on June 21, 2021 in Chicago, Illinois before Arbitrator Rachael Sinnen on Petitioner's Request for Hearing. Issues in dispute include accident, causal connection, medical bills, temporary total disability "TTD" benefits, penalties, and nature and extent of the alleged injury. (Arbitrator's Exhibit "Ax"1). The trial was continued to July 22, 2021 to allow Petitioner's counsel to obtain the necessary certifications for medical records submitted into evidence. (Tr. 61-65).

Testimony of Petitioner, Martha Lira

On August 3, 2020, Petitioner, Martha Lira, was employed by Respondent, Cook County Clerk's Office, where she worked as a Clerk. (Tr. 9). Petitioner testified that she had been employed for 27 years prior to August 3, 2020. On this date, Petitioner testified that she fell in the women's bathroom and after falling, she noticed water on the floor. (Tr. 11). Petitioner testified that while she was in the bathroom, no one else entered the restroom until after the fall and her request for help. (Tr. 27). Petitioner stated that her fall was not witnessed. (Tr. 31). Petitioner testified that she yelled for assistance and that an ambulance was called. (Tr. 11). Petitioner testified that she felt pain in her buttocks following the fall and that soon after the fall, she spoke with one of the Human Resource employees, Yolanda, about what had occurred. (Tr. 14).

Petitioner testified that she was transported by ambulance to Northwestern emergency room. (Tr. 19). The emergency room performed x-rays, restricted Petitioner's ability to work and instructed to follow up with her primary care doctor. (Tr. 19; Petitioner's Exhibit "Px" 1). Ms. Lira followed up with MacNeal Family Medicine between August 6, 2020 and August 28, 2020. (Tr. 21). During the time period Ms. Lira saw MacNeal Family Medicine she was restricted from working. (Tr. 21).

Petitioner further testified that she began treating with Dr. Matthew Coleman at Rush beginning October 12, 2020 and that she was off work due to her doctor's recommendations. (Tr. 21). Petitioner described conservative treatment provided by Dr. Coleman including an ice pack, medication, physical therapy, and injections. (Tr. 22). Petitioner testified that Dr. Coleman

released her from care on June 15, 2021. (*Id*.). Presently, Petitioner's low back pain still comes and goes. (Tr. 23).

Petitioner testified that even though she has been released to return to work, that she has not returned to her previous position. (Tr. 26). Petitioner testified that her employment ended with Respondent near the end of August when she was fired. (Tr. 32). The parties stipulated that Petitioner was fired for an alleged performance issue that occurred with Ms. Lira through her employer prior to August 3, 2020, the date of her accident. It was also be stipulated that after August 3, 2020 she was fired for that alleged performance issue. At the time of trial, Petitioner's termination was still in the union grievance process and is still in pending litigation. (Tr. 39).

Petitioner testified that she was examined on February 16, 2021 by Dr. Alpesh A. Patel at Respondent's request. (Respondent's Exhibit "Rx" 1). Petitioner testified that Respondent did not pay temporary total disability benefits or pay for her medical treatment while treating for this alleged event. (Tr. 33). Petitioner's Exhibit 5 consists of a list of unpaid medical bills for showing no payments from workers compensation. (Tr. 23).

Testimony of Respondent's witness, Holly Figliuolo

Petitioner testified that Holly Figliuolo did enter the women's bathroom shortly after the alleged fall on August 3, 2020. Ms. Figliuolo testified that she too works for Respondent but as an Executive Administrative Assistant to the Deputy of Election and that she was also working on August 3, 2020. (Tr. 42). Ms. Figliuolo testified that employee Renee Kennedy advised her that Petitioner had fallen in the bathroom. (Tr. 44). Ms. Figliuolo stated that she then entered the bathroom and witnessed Petitioner and employee Jenny Lemon in the bathroom. (Tr. 45). Ms. Figliuolo testified that she was able to see Petitioner's feet which were sticking out from the stall but did not see Petitioner's face as the stall's door was closed. (Tr. 46). Ms. Figliuolo testified when she entered the bathroom, Petitioner was very calm and quiet and, after asking Petitioner if she was 'all right,' Petitioner began crying. (*Id*.).

Ms. Figliuolo stated that she observed that Petitioner's shoes were dry and that she did not see any water in the area where Petitioner fell. (Tr. 52). However, the entire time Ms. Figliuolo was in the bathroom Ms. Lira's stall door was closed. (Tr. 49). Ms. Figliuolo stated, "There was no visible water from where I was standing, but I didn't go into the stall with her, so I didn't see where she was." (Tr. 52).

Respondent's Section 12 Examination, Dr. Alpesh A. Patel

Petitioner was examined pursuant to Respondent's request under Section 12 of the Act on February 16, 2021 by Dr. Alpesh A. Patel. Dr. Patel, a doctor of Orthopedic Medicine at Northwestern Medicine, reported that he reviewed various medical reports including reports from Northwestern Memorial Hospital, Loyola MacNeal Family Medicine, Midwest Orthopedics at Rush and several diagnostic reports relating to Petitioner's medical treatment following her alleged injury on August 3, 2020. (Rx 1). Dr. Patel created a report summarizing the history of medical treatment and describing his oral and physical examination of Petitioner. (*Id*. at 2-4). Dr. Patel concluded that Petitioner sustained a lumbar strain likely as a result of a fall in the bathroom

as described but that Petitioner also had underlying preexisting degenerative changes in the lumbar spine. (*Id*. at 5). Dr. Patel opined that Petitioner's medical treatment was appropriate and that no further treatment including injections were necessary. Lastly, Dr. Patel wrote that Petitioner would be able to return to work based on her description of her job position. (*Id*.).

CONCLUSIONS OF LAW

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

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972).

It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010).

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds her to be a credible witness. Petitioner was straight forward, appropriately dressed, and maintained good eye contact with the Arbitrator while testifying. The Arbitrator compared Petitioner's testimony with the totality of the evidence submitted and did not find any material contradictions that would deem the witness unreliable.

Issue C, whether the accident arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The phrase "in the course of employment" refers to the time, place, and circumstances of the injury. McAllister v. Illinois Workers' Compensation Comm'n, 2020 IL 124848, ¶ 34. A compensable injury occurs 'in the course of' employment when it is sustained while he performs reasonable activities in conjunction with his employment. Id.

Under the personal comfort doctrine, injuries sustained by an employee while in the performance of reasonably necessary acts of personal comfort may be found to have occurred 'in the course of' her employment, since they are incidental to the employment. Chicago Extruded Metals v. Industrial Comm'n, 77 Ill. 2d 81, 84, 395 N.E.2d 569, 32 Ill. Dec. 339 (1979). The personal comfort doctrine does not answer the whole question of compensability because it addresses only the "in the course of" requirement; the "arising out of" requirement must be met

independently. Circuit City Stores, Inc. v. Illinois Workers' Compensation Comm'n, 391 Ill. App. 3d 913, 920-21 (2nd Dist. 2009).

"The 'arising out of' component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." Id. at ¶ 36. To determine whether a claimant's injury arose out of his employment, the risks to which the claimant was exposed must be categorized. Id. The three categories of risks are "(1) risks distinctly associated with the employment; (2) risks personal to the employee (such as idiopathic falls); and (3) neutral risks which have no particular employment or personal characteristics." Id. at ¶ 38.

An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of falling or the effects of the fall. First Cash Financial Services v. Industrial Comm'n (Rios), 367 Ill. App. 3d 102, 105, 853 N.E.2d 799, 803-04 (1st Dist. 2006) *citing* Stapleton v. Industrial Comm'n, 282 Ill. App. 3d 12, 16, 668 N.E.2d 15, 217 Ill. Dec. 830 (1996). In this case, there is no evidence that Petitioner suffered from a physical condition that caused her to fall. Accordingly, Petitioner's fall was not idiopathic in nature.

For an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. Builders Square, Inc. v. Industrial Comm'n, 339 Ill. App. 3d 1006, 1010, 791 N.E.2d 1308, 274 Ill. Dec. 897 (2003). Employment related risks associated with injuries sustained as a consequence of a fall can include the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling. First Cash Financial Services at, 106; Nabisco Brands, Inc. v. Industrial Comm'n, 266 Ill. App. 3d 1103, 1107, 641 N.E.2d 578, 204 Ill. Dec. 354 (1994).

Here, Petitioner's accident arose out of and in the course of her employment. Petitioner credibly testified that she fell in the women's bathroom and noticed water on the floor where she fell. Respondent's witness was not able to credibly rebut Petitioner's claim as she admitted that she never entered the bathroom stall where Petitioner fell. As a result, the Arbitrator finds that Petitioner has met her burden in providing accident.

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

The Arbitrator finds that Petitioner has met her burden in proving that her current condition of ill-being is causally related to her work injury of August 3, 2020.

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. 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. Even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show

that his employment was also a causative factor. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." International Harvester v. Industrial Com., 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982).

Emergency room records document a history of a 46-year-old female with low back pain after she slipped on some water at work and landed on her low back. (See Px 1). Three days after the accident, Petitioner's primary care physician documents a history of a patient who slipped on water at work about three days ago. Petitioner was diagnosed with an "injury to her low back at work, left sided in nature due to fall." (See Px 3).

On October 13, 2020, Dr. Mathew Coleman, a lumbar orthopedic from Midwest Orthopedics takes a history of "patient is employed as an administrative assistant for the cook county clerk office and was injured on August 3, 2020 when she fell backwards in bathroom stall after slipping on water on floor." Dr. Coleman diagnosed Petitioner with discogenic radiating low back pain secondary to an August 3, 2020 fall at work. (See Px 4).

Based on Petitioner's credible testimony corroborated by the medical records as well as the medical opinions in this case, the Arbitrator finds Petitioner's present condition of ill being causally related.

Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Having found that Petitioner's condition of ill being is causally related to her work accident, the Arbitrator also finds Petitioner's treatment to be reasonable and necessary and finds that Respondent has not paid for said treatment. The Arbitrator considers the medical opinions of Respondent's Section 12 examiner, Dr. Patel (that Petitioner did not require any further medical care). However, the Arbitrator finds the opinions of Petitioner's treating doctors to be more credible.

As such, the Arbitrator orders Respondent to pay Petitioner directly for the outstanding medical services contained within Petitioner's Exhibit 5, pursuant to the medical fee schedule and Sections 8(a) and 8.2 of the Act. The parties stipulated that Respondent shall be afforded a credit under 8(j) for any medical bills paid through its group insurance. (See Ax 1).

Issue K, whether Petitioner is entitled to any temporary total disability benefits, the Arbitrator finds as follows:

Having found that Petitioner has met her burden regarding causation as well as the reasonableness and necessity of treatment, the Arbitrator finds that Petitioner is entitled to TTD benefits. Relying on the medical records provided as well as Petitioner's credible testimony, Petitioner was off work

from August 3, 2020 (the date of accident) through June 15, 2021 when she was released from Dr. Coleman's care. While the Arbitrator considers the medical opinions of Dr. Patel (that Petitioner could return to work at the time of his examination), the Arbitrator finds the opinions of Petitioner's treating doctors to hold more weight.

As such, Arbitrator finds Respondent liable for 45 1/7 weeks of TTD benefits (August 4, 2020 through June 15, 2021) at a weekly rate of $794.13, which corresponds to $35, 849.45 to be paid directly to Petitioner. Respondent did not claim any credit for TTD paid. (See Ax 1).

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

In determining PPD benefits, Section 8.1b(b) of the Act directs the Commission to consider: "(i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records." 820 ILCS 305/8.1b(b); Con-Way Freight, Inc. v. Illinois Workers' Compensation Comm'n, 2016 IL App (1st) 152576WC, ¶ 22, 67 N.E.3d 959. "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b).

Under Section 8.1b(b)(i), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The statute does not require the claimant to submit an impairment rating. It only requires that the Commission consider such a report if in evidence and regardless of which party submitted it. See Continental Tire of the Americas, LLC v. Illinois Workers' Compensation Comm'n, 2015 IL App (5th) 140445WC, ¶ 17, 43 N.E.3d 556. Therefore, the Arbitrator gives no weight to this factor.

Under Section 8.1b(b)(ii), the occupation of the injured employee, the Arbitrator therefore gives little weight to this factor. Although Petitioner was terminated, she did briefly return to work for Respondent.

Under Section 8.1b(b)(iii), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 46 years old at the time of the accident. The Arbitrator gives little weight to this factor.

Under Section 8.1b(b)(iv), the employee's future earning capacity, the Arbitrator notes that Petitioner did briefly return to work for Respondent prior to termination. There was no evidence that she sustained any reduction in her earnings upon return. As such, the Arbitrator gives little weight to this factor.

Under Section 8.1b(b)(iv), evidence of disability corroborated by the treating medical records, the Arbitrator gives significant weight to this factor. Dr. Coleman diagnosed Petitioner as suffering from L4-L5 spondylolisthesis. (See Px 6). Petitioner underwent two epidural injections for this injury and performed over approximately 10 months of conservative care. Petitioner still experiences periodic low back pain at the time of trial. (See Tr. 23).

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 6% loss of person as a whole pursuant to §8d2 of the Act which corresponds to 30 weeks of permanent partial disability benefits at a weekly rate of $714.72 for a total of $21,441.60.

Issue M, whether penalties or fees should be imposed upon Respondent, the Arbitrator finds as follows:

The Arbitrator declines to impose penalties or fees upon Respondent based on its witness' testimony and the opinions of its Section 12 examiner.

It is so ordered:

Arbitrator Rachael Sinnen

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC031646
Case Name	MCCANDREW, SHELBI v. STATE OF ILLINOIS/ ALTON MENTAL HEALTH
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0154
Number of Pages of Decision	17
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Caitlin Fiello

DATE FILED: 4/27/2022

/s/ Thomas Tyrrell, 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

McCANDREW, SHELBI,

Petitioner,

vs. NO: 19 WC 31646

SOI/ALTON MENTAL HEALTH,

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 Respondent's Motion for Continuance of Trial to allow for Section 12 Addendum, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 2, 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.

April 27, 2022

o041222
TJT/ldm
051

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0154

McCANDREW, SHELBI
Employee/Petitioner

Case# **19WC031646**

20WC002063

SOI/ALTON MENTAL HEALTH
Employer/Respondent

On 12/2/2020, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0000 ASSISTANT ATTORNEY GENERAL
CAITLIN FIELLO SCHWARTZ
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
SPRINGFIELD, IL 62794

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

DEC 2 - 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHELBI MCCANDREW
Employee/Petitioner

v.

STATE OF ILLINOIS/ALTON MENTAL HEALTH
Employer/Respondent

Case # 19 WC 31646

Consolidated cases: 20-WC-02063

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 28, 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 _____

FINDINGS

On **October 8, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$88,833.16**; the average weekly wage was **$1,708.33**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit 1, as provided in §8(a) and §8.2 of the Act. Respondent shall have credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit.

Respondent shall pay Petitioner temporary total disability benefits of **$1,138.89**/week for the period **10/8/19 through 11/18/19 and 12/19/19 through 12/23/19,** representing **6-5/7** weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$836.69 (Max. rate)**/week for **50** weeks, because the cardiac injury sustained caused **10%** loss of the **body as a whole**, as provided in §8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **$836.69 (Max. rate)**/week for **10.75** weeks, because the right knee injury sustained caused **5%** loss of the **right leg**, as provided in §8(e) of the Act.

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

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

Signature of Arbitrator

11/27/20
Date

DEC 2 - 2020

STATE OF ILLINOIS)
) **SS**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHELBI MCCANDREW,
Employee/Petitioner,

v.

STATE OF ILLINOIS/ALTON MENTAL HEALTH,
Employer/Respondent.

Case No.: 19-WC-31646
Consolidated Case No.: 20-WC-2063

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on September 28, 2020. On October 30, 2019, Petitioner filed an Application for Adjustment of Claim alleging injuries to her right knee, chest, heart, and body as a whole as a result of being attacked by a combative patient on October 8, 2019. On January 23, 2020, Petitioner filed an Application for Adjustment of Claim alleging injuries to her right knee as a result of slipping and falling on ice in Respondent's parking lot on December 18, 2019. The cases have been consolidated. The issues in dispute in the present case (Case No. 19-WC-31646) are accident, causal connection, medical bills, temporary total disability benefits, and the nature and extent of Petitioner's injuries. All other issues have been stipulated.

TESTIMONY

Petitioner was 48 years old, single, with two dependent children at the time of the accident. Petitioner testified she has been employed at Respondent's Alton Mental Health facility for three years as a Registered Nurse II. Her job involves caring for patients that are criminally insane and unfit to stand trial. Petitioner's job duties include administering medication, supervising staff, and physically holding or restraining patients. Petitioner testified she worked 16-hour shifts four days per week due to Respondent's overtime mandates.

Petitioner testified that on 10/8/19 she was involved in an altercation with a combative patient. The patient blockaded herself in the bathroom and was banging her head on the bathroom concrete wall. Petitioner and a coworker forced their way into the bathroom, and Petitioner tried to guard the patient from hitting her head or causing further bodily harm. Petitioner was kicked in the right knee and chest, bitten, and spat on by the patient. The patient was 5'11" and very strong and Petitioner had to hold the patient in a burrito wrap until they would get her in the restraint room. Petitioner testified she felt her heart racing during the

incident and initially thought it was just adrenalin. Petitioner subsequently began having difficulty breathing.

Petitioner testified that her coworker, Jason Phillips, was under the sink with her and he noticed Petitioner was in distress and called for assistance to remove Petitioner from the area. Petitioner returned to the nursing station after the incident to tend to patient matters and placed a pulse oximeter on her finger due to her increased heart rate. Petitioner testified that prior to the accident she took Metoprolol for high blood pressure, but she has never had an issue with her heart.

Although there are surveillance cameras throughout the facility, there are no cameras in the restroom where the incident occurred. The surveillance video admitted into evidence by Respondent does contain footage of the door where Petitioner pushed her way inside the restroom. Petitioner testified she reported the incident to her supervisor and filled out an incident report that was consistent with her testimony. A statement was prepared by Ms. Travis who stated Petitioner helped restrain the combative patient and afterwards Petitioner called her to feel her elevated pulse and was eventually taken away by ambulance. Coworker Larry Wylie prepared a statement stating he observed Petitioner and three other employees under the sink getting kicked, scratched, spit on and bitten by the patient. Mr. Wylie was advised that an ambulance was called and he guided the EMTs to where Petitioner was sitting. He noted Petitioner was very pale and the EMTs assessed her O2 level was low, her heart rate was over 200". They applied oxygen and transported Petitioner to St. Anthony's Medical Center.

Respondent's physician on duty, Dr. Yusuf Moyhuddin, also completed an incident report. Petitioner called Dr. Moyhuddin to be assessed following the incident. Dr. Moyhuddin reported that when he arrived, Petitioner was sitting in the kitchen area with a pulse oximetry machine attached to her finger. Petitioner had palpitations and shortness of breath, her heart rate fluctuated between 200 and 220, and he noted Petitioner was in obvious distress. He immediately told her to call an ambulance and go the emergency room. His report notes that Petitioner then contacted control, who in turn called 911. Dr. Mohyuddin reported that Petitioner told him she was involved in a very difficult situation including a complicated patient who needed to be physically restrained and taken to the restraint room. Petitioner reported to him that restraining the patient brought about her fast heart rate, extreme anxiety, shortness of breath, and chest pain. Petitioner denied any symptoms prior to encountering the patient. Dr. Mohyuddin indicated that he called and spoke with the ER physician about Petitioner before EMS arrived to transport her.

The incident report completed by Petitioner's supervisor, Ann Hoffstetter, states that an employee who requested her name remain anonymous accused Petitioner of consuming "some type of substance on 10/8/19 which caused her to have a rapid heart rate." The employee would not tell the reporting personnel what Petitioner consumed or how she knew said information. Petitioner testified that her call to Ann Hoffstetter was not a pleasant phone call and she ended up hanging up on her and then called Dr. Mohyuddin. Petitioner's incident report details her supervisor's expletive laden remarks to her on the phone and later when her supervisor entered the medical room door prior to Dr. Mohyuddin sending her to the emergency room. Ann Hoffstetter was not present to testify at arbitration.

Petitioner testified she initially placed the pulse oximetry on her finger after she called Dr. Mohyuddin and she wore it while continuing her job duties and until EMTs arrived to transport her.

Petitioner testified she was diagnosed with a small heart attack and underwent a cardiac catheter the following morning. Petitioner testified she reported knee pain to the ER physician and he ordered an x-ray. She followed up with her primary care physician who ordered an MRI of her right knee. She was referred to Dr. Becton who prescribed a knee brace and physical therapy. Petitioner was referred to Dr. Saha for her cardiac condition and he performed a cardiac ablation. Petitioner contributed her cardiac condition to stress from the incident and fatigue from mandatory overtime work. Petitioner testified she worked back-to-back 8-hour shifts, lives one hour from work, and only had time for a few hours of sleep before her next 16-hour shift started.

Petitioner testified she was off work from 10/8/19 through 11/18/19. She suffered a second injury to her right knee on December 18, 2019, when she slipped and fell in Respondent's icy parking lot while on her way to an annual CPI class. Petitioner filed a second Application for Adjustment of Claim on 1/23/20 bearing Case No. 20-WC-2063 that was not consolidated but tried simultaneously with the above-captioned case. Petitioner testified that the State owns and maintains the parking lot where she fell on 12/18/19 and stated that the area where she parked was restricted from the general public. There was a light dusting of snow and black ice on the parking lot. Petitioner testified the sidewalks were salted and the parking lot had not been salted where she parked.

Petitioner testified that despite the improvement from her treatment, she has no heat tolerance and has difficulty engaging in activities she enjoyed such as working in her yard and garden, as she easily becomes exhausted. She also testified her right knee locks up and gives out on her at times, particularly with prolonged walking or sitting. She testified she has trouble running to codes at work and has anxiety about having heart troubles again while responding to a code call. She takes Tylenol or Aleve for her knee symptoms. She takes Cardizem for her cardiac condition.

Respondent called Shannon LaPlant as a witness. Ms. LaPlant is Respondent's Workers' Compensation Coordinator and testified she received a Notice of Injury from Petitioner and obtained the video surveillance of the day of accident. Ms. LaPlant confirmed that no surveillance cameras are mounted in restrooms or bedrooms. Ms. LaPlant testified she was able to recognize Petitioner and her coworkers in the surveillance video. She also observed Petitioner wearing the pulse oximetry on her finger. The video depicts Petitioner leaving the doc station and entering the kitchen. Ms. LaPlant testified, however, that she was not present during the incident and did not learn of its occurrence until two or three days later. Ms. LaPlant testified that the report she made was not about the incident itself, but was made at the request of Respondent to report additional details and forms Respondent requested her to gather.

Respondent called Debra Meyer, Clinical Nurse Manager, to testify. Ms. Meyer has been a nurse for 38 years and worked for Respondent since 2014. Ms. Meyer testified that pulse oximetry machines are used to check oxygen saturation for individuals short of breath and detect heart rate. She testified that a rate greater than 100 is classified as high by the American Heart Association. She testified that if the pulse oximetry gave a high reading and a manual heart rate

check corroborated the high reading it would constitute a medical emergency. Ms. Meyer testified that Petitioner is a good employee and she had no reason to believe Petitioner was not honest. Ms. Meyer was not working with Petitioner on the date of Petitioner's incident.

Respondent called Wenter Hurst, a Security Therapy Aide I, to testify. Ms. Hurst testified she entered the bathroom at the same time as Petitioner to restrain the patient. She confirmed that the patient was beating her head against the sink and floor and became aggressive. Ms. Hurst stated the patient would kick, punch, and bite when she was outraged. She believed the patient hit all of the staff, including Petitioner, but did not see the patient kick Petitioner. Ms. Hurst testified that Petitioner did not mention to her that she was out of breath or having a heart attack. Following the incident, Ms. Hurst observed Petitioner on the phone sitting in the doc station. She observed Petitioner to be out of breath. She next saw Petitioner in the kitchen for a few seconds when Petitioner "flopped down" in a chair to rest. Ms. Hurst acknowledged that she and Petitioner were involved in a stressful situation trying to restrain a combative person. She testified that Petitioner was "moving around a lot" and that a code restraint typically requires a lot of constant back and forth to manage the patient and do paperwork. She testified that she was present when the ambulance arrived but did not see Petitioner's transport.

Respondent called Nicole Hinton, a Mental Health Technician, to testify. Ms. Hinton testified she responded to the code call and arrived at the restroom where Petitioner and several others were already engaged in the restraint. She testified she did not see Petitioner get kicked by the patient, nor did she notice Petitioner in distress. She testified that after the incident she next saw Petitioner enter the kitchen and sit down at which time Petitioner was complaining of her supervisor. She observed Petitioner walking and did not notice a limp. She observed Petitioner put the pulse oximetry on her finger and was present when an ambulance was called. Ms. Hinton testified she could not recall whether she prepared a witness report, and she confirmed that Petitioner was already in the restroom dealing with the patient before she arrived. She was aware Petitioner was taken by ambulance but unaware that Petitioner was evaluated by Dr. Mohyuddin prior to her transport. She was further unaware of the nature of Petitioner's injuries or whether Petitioner had any heart problems prior to this accident.

MEDICAL HISTORY

Petitioner was taken via ambulance to Saint Anthony's Health Center, where she was admitted for a chief complaint of rapid heart rate. A history of the patient altercation was recorded, including her knee injury, and it was noted that Petitioner's initial pulse oximetry measured her heart rate in the 220s. By the time Petitioner reached the emergency department her blood pressure remained elevated in the 110s/120s. The attending provider noted Petitioner's manager would not let her leave. It was also noted Petitioner was wheezing, had chest pain, and Petitioner had been working six days a week, 16- hour shifts due to staff shortage, and Petitioner was not getting much sleep. X-rays of Petitioner's chest and an EKG were unremarkable, but Petitioner's labs were positive for elevated troponin at 0.838. Petitioner underwent cardiac catheterization, which demonstrated findings of hyperdynamic left ventricular systolic function, elevated left ventricular filling pressures, and probable uncontrolled hypertension based on the corkscrew nature of the coronary arteries. Clinical impression was non-ST elevated myocardial infarction and tachycardia. Petitioner also reported right knee pain and x-rays were normal.

Petitioner was given Cardizem in addition to the Metoprolol she took for hypertension and instructed to follow up with her primary care physician and the cardiology department.

Petitioner presented to her primary care physician, Dr. Pamela Lowry at Washington County Rural Health, for follow-up care. A consistent history of accident was reported and Petitioner stated she began having chest pains during the altercation. Petitioner used a pulse ox following the incident and noted her heart rate to be 220. She reported she felt like she was going to pass out. She reported she called her supervisor who yelled at her and Petitioner hung up the phone. Petitioner reported that the supervisor came to the med room and proceeded to yell at her. The supervisor told her she herself had the flu and should not be outside of her office. Petitioner reported that the stress at work is extremely high, she hardly gets any sleep when mandated to work double shifts and has to be back the next morning. Petitioner stated she gets off work at 11:00 p.m. and by the time she drives one hour home and gets to bed at 1:00 a.m., she has to get up before 4:30 a.m. in order to report to work by 6:30 a.m. She reported that her work conditions and mandated hours has caused undue stress emotionally, physically, and mentally.

The history further noted that Petitioner developed moderate-to-severe right knee pain after she was kicked by the patient during the altercation. Petitioner described her pain as burning, piercing, sharp, constant, and progressive. Associated symptoms included crepitus and decreased mobility. Petitioner was noted to be tearful when talking about her health and work demands during physical examination. Examination showed mild right knee effusion with maximum tenderness over the right medial joint line, guarded medial McMurray's testing, positive pivot shift testing, and positive valgus stress testing. Dr. Lowry assessed SVT (supraventricular tachycardia) and right medial knee pain. Conservative treatment was recommended, including medication and ice for Petitioner's right knee, and she was taken off work for four weeks.

Petitioner presented to Dr. Marras at Prairie Cardiovascular on 10/24/19. Dr. Marras noted a consistent history of the injury and that Petitioner had several different heart rates. Suspecting that one of the rates may have been different than SVT or that Petitioner may have more than one SVT circuit, he arranged for a 30-day event monitor and referred her to Dr. Saha for consultation for an ablation. Dr. Saha recommended electrophysiology studies (EPS) and catheter ablation.

Petitioner returned to Dr. Lowry on 10/30/19 at which time Petitioner's symptoms progressed to include nocturnal awakening, numbness, popping, clicking, and throbbing pain in the right knee, in addition to crepitus, joint tenderness, and swelling. Petitioner was still experiencing tachycardia and was being monitored by a cardiologist. Physical examination continued to show positive orthopedic testing with maneuvers such as Thessaly's. An MRI was ordered and Ms. Lowry referred Petitioner to Dr. Paletta for further evaluation.

Petitioner underwent cardiac ablation by Dr. Saha at St. Elizabeth's Hospital on 12/19/19. During the procedure, the slow pathway was mapped for electrograms and junctional ectopy was noted. Following the procedure, isoproterenol was transfused to achieve a resting heart rate less than 100 beats per minute. The concluding analysis was successful slow pathway modification, and Petitioner was advised to get rest and continue her home medications.

The right knee MRI was performed on 12/27/19 and she followed up with Dr. Paletta's partner, Dr. Wendell Becton. Dr. Becton noted Petitioner has experienced persistent pain and a feeling of weakness in her right knee since being kicked by a patient on 10/8/19. Dr. Becton noted Petitioner's second right knee injury on 12/18/19 when she slipped on ice and landed directly on her knee. He noted Petitioner's initial treatment of Diclofenac 75 mg which did not improve her pain. The MRI showed mild tendinopathy of the medial gastrocnemius tendon as well as reactive soft tissue and bone marrow edema in that area. Petitioner reported her right knee hurts after standing for long periods of time and when she gets up from a seated position. She denied having any previous right knee surgeries or injuries.

Dr. Becton noted Petitioner had not had physical therapy and found Petitioner's MRI was positive for reactive soft tissue at the medial gastroc muscle area proximally with some tibial marrow edema and mild patellofemoral and medial femoral compartment arthritis. His impression was right medial knee contusion with proximal gastroc muscle strain injury. He prescribed physical therapy, a supportive Kneesio brace, and a medication regimen of Diclofenac and Meloxicam. He allowed Petitioner to return to work but restricted her from overtime for the next 8 weeks.

Petitioner returned to Dr. Becton on 3/24/20 after undergoing some physical therapy at Apex Physical Therapy. Petitioner's therapy was interrupted by the outbreak of COVID-19. Petitioner continued to have pain and tenderness in the medial right knee area. Petitioner felt well enough to return to work. Dr. Becton opined Petitioner's right knee condition was directly work related and desired Petitioner to continue physical therapy. He believed Petitioner would reach maximum medical improvement within two to three months.

Petitioner last saw Dr. Becton via Facetime on 5/12/20 at which time she reported doing well after returning to work, with occasional knee pain rated 2-3 out of 10. He recommended Petitioner continue home knee exercises on a regular basis, advised her to continue using Meloxicam as needed, and lifted her overtime restrictions.

On 2/3/20, Petitioner was examined by Dr. Michael Nogalski pursuant to Section 12 of the Act with respect to her right knee. Dr. Nogalski reviewed the history of accident and Petitioner's medical records and noted Petitioner was kicked by the patient in her right knee. Examination showed generalized tenderness in the medial joint line, medial femoral condyle, and medial tibial plateau. Dr. Nogalski noted residual tenderness with maximal hamstring stretch. His review of the MRI showed broad signal changes in the medial gastroc, indiscriminate bone marrow signal changes along the subchondral zone of the medial tibial plateau, a cyst centrally in the tibia without reactive signal changes around it, and some chondrosis of the medial and patellofemoral compartments. He noted that although a majority of the witness reports focused on her cardiac symptoms, Petitioner's Notice of Injury and medical records indicated she was kicked in her right knee.

Dr. Nogalski believed Petitioner had some preexisting medial patellofemoral chondrosis in her right knee but noted there were some objective findings of signal changes in the medial gastrocnemius. He believed Petitioner may have had some reactive bone marrow edema from the

accident. His assessment was status post right knee contusion and possible gastrocnemius strain either due to a direct blow injury or strain during the altercation of 10/8/19. Dr. Nogalski opined there is a reasonably causal relationship between Petitioner's signal change within the gastrocsoleus area and reported accident. Bone marrow signal issues are somewhat indeterminant and she might have or could have sustained a bone contusion given the type of activities she described in restraining the patient. He further concluded that Petitioner's medical treatment to date was reasonable, including the right knee MRI, to assess and treat her right knee.

On 3/13/20, Petitioner was examined by Dr. Stephen Schuman with respect to her heart condition. Dr. Schuman took a consistent history of the incident, reviewed Petitioner's medical records, and noted Petitioner was sent to the emergency department by Respondent's medic on duty, Dr. Moyhuddin. He also noted that witness reports gave basically similar accounts. Dr. Schuman noted Petitioner's initial heart rate was fluctuating between 200 and 220 and that after her conversion EKG's showed tachycardia in the 130's with occasional premature ventricular contractions (PVCs). After performing his own physical examination which noted objective findings of a normal electrocardiogram and a normal physical examination, Dr. Schuman's assessment was non-ST elevation myocardial infarction on 10/8/19, likely due to coronary artery spasm associated with supraventricular tachycardia. Dr. Schuman opined there is a causal relationship between Petitioner's non-ST elevation myocardial infarction (with associated episode of SVT) and the reported accident. He further concluded that Petitioner's medical treatment to date had been reasonable and necessary, and that necessary additional treatment would include remaining on Cardizem CD (Diltiazem) for prevention of possible coronary artery spasm and prevention of recurring episodes of SVT.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 117 Ill.2d 38, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work or that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.* "An accidental injury can be found to have occurred, even though the result would not have obtained had the employee been in normal health. [Citation.] If an employee's existing physical structure gives way under the stress of his usual labor, [it] is an accident which arises out of his employment." *Baggett v. Indus. Comm'n*, 201 Ill. 2d 187, 195, 775 N.E.2d 908, 913 (2002), as modified on denial of reh'g (Aug. 29, 2002) citing *County of Cook v. Indus. Comm'n*, 69 Ill.2d 10, 370 N.E.2d 520 (1977).

The Arbitrator places significant weight on Petitioner's two-page recitation of the accident, the witness reports which support Petitioner's account of the incident, and the medical records which consistently document her cardiac and right knee symptoms began as a result of the stressful and physically demanding restraint of a combative patient on October 8, 2019. Petitioner reported dizziness, chest pain, shortness of breath, and an increased heart rate during

and immediately following the incident, resulting in emergent treatment and a cardiac catheter and ablation. Petitioner testified she did not have heart issues prior to 10/8/19.

Petitioner testified without rebuttal that her employment overall is stressful, as she is tasked with caring for the criminally insane and had worked excessive overtime for some time prior to the incident. Based on the evidence and medical records, the Arbitrator finds that Petitioner suffered a heart attack that arose out of and in the course of her employment with Respondent.

Petitioner's testimony with regard to her right knee injury is also credible and supported by the evidence. All of Respondent's witnesses who witnessed the altercation acknowledged the patient was extremely combative, and was kicking, biting and scratching at all of the employees who attempted to restrain her. Further, the emergency room records confirm Petitioner complained of right knee pain, which was also documented by her primary care physician and Dr. Becton. Additionally, Respondent's own examiner, Dr. Nogalski, agreed that Petitioner's right knee condition could have resulted from a direct blow or a strain injury.

Based on the foregoing, the Arbitrator finds Petitioner satisfied her burden of proof in establishing that she suffered accidental injuries to her body as a whole (heart attack) and right knee that arose out of and in the course of her employment with Respondent.

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

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). The law holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003). [Emphasis added]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 309 Ill. App. 3d 1037, 723 N.E.2d 846 (2000). Employers are to take their employees as they find them. *A.C. & S. v. Indus. Comm'n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Indus. Comm'n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (1967), 37 Ill. 2d 123; see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

With respect to Petitioner's heart attack, the Arbitrator finds the matter of *Twice Over Clean, Inc.* instructive. *Twice Over Clean, Inc. v. Indus. Comm'n*, 214 Ill. 2d 403, 405, 827 N.E.2d 409, 409 (2005). In that case, the Claimant was a laborer who began suffering from chest pains while performing heavy labor in inclement weather conditions. *Id.* He finished his work, went to his hotel, and did not feel like eating. *Id.* When he again experienced chest pains and broke out in a cold sweat, he was taken to the hospital via ambulance, where he was admitted and diagnosed with an acute inferior myocardial infarction. *Id.* He filed a workers' compensation claim seeking recovery for his heart attack, and his employer disputed whether the injury arose

out of and in the course of his employment. *Id.* Though the Arbitrator, Commission, and Circuit Court found that the evidence supported that the heart attack arose out of and in the course of employment, the Appellate Court reversed, placing emphasis on the point that the claimant was a "heart attack waiting to happen" and could have suffered same even while at rest, and found the normal daily activity exception applied to defeat his claim. *Id.* N.E.2d at 412. Even after the Supreme Court entered a supervisory order directing the Appellate Court to reconsider its opinion in light of the recent *Sisbro* case, the Appellate Court again set aside the Commission's award and the Circuit Court's judgment. *Id.* On appeal, the Supreme Court reversed and reinstated the Commission's award of benefits, rejecting the argument that the "normal daily activity" bars recovery when the record establishes that a work incident brought about the actual condition of ill-being. *Id.* at N.E.2d 413, 416. The Supreme Court cited other cases where claimants with preexisting heart conditions and even prior heart attacks were deemed to have compensable injuries. *Id.* at 414-15 citing *Rock Road Construction Co. v. Indus. Comm'n*, 37 Ill.2d 123, 227 N.E.2d 65 (1967) (wherein claimant who previously suffered two myocardial infarctions, carried nitroglycerin pills, and was sensitive to cold weather was awarded benefits for a fatal heart attack that occurred in the course of his employment as an asphalt truck driver after rolling up and down his tarpaulin and dumping a load of asphalt); and *County of Cook v. Indus. Comm'n*, 69 Ill.2d 10, 370 N.E.2d 520 (1977) (wherein claimant also had prior history of myocardial infarction and died following a period of unusually busy work in his office). The Court again pointed out that a claimant need only prove that some act of phase was a causative factor in the resulting injury. *Id.*

In the present case, Petitioner suffered a myocardial infarction as a direct result of the strain she endured while restraining a combative patient. Respondent's own independent medical examiner, Dr. Schuman, causally relates Petitioner's heart attack to the altercation incident. Respondent likewise produced no evidence to rebut the chain of events and the report of its own independent medical examiner, Dr. Nogalski, linking Petitioner's right knee condition to the altercation incident. The record demonstrates that Petitioner was able to work full duty without restrictions and the record reveals no prior significant history for either her right knee or heart problems. The Arbitrator therefore finds no basis in the record for Respondent's dispute of causal connection and finds that Petitioner met her burden in proving that her heart condition and right knee condition are causally related to the altercation that occurred on 10/8/19.

With respect to Petitioner's second accident that occurred on 12/18/19, the Arbitrator finds little evidence that it had a significant impact on Petitioner's condition of ill-being in her right knee. There appeared to be no change in Petitioner's symptoms or in the treatment and evaluation of same; therefore, the Arbitrator finds the accident of December 18, 2019 was nothing more than a temporary exacerbation of her initial injury on 10/8/19. *Lasley Construction Co. v. Industrial Comm'n,* 274 Ill.App.3d 890, 893, 655 N.E.2d 5 (1995) (holding that "other incidents, whether work-related or not, may have aggravated the claimant's condition is irrelevant"). Therefore, the Arbitrator finds no intervening accident occurred and that Petitioner's right knee symptoms remain the result of the altercation that occurred on October 8, 2019.

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?

Upon establishing causal connection and the reasonableness and necessity of the recommended medical treatment, employers are responsible for the medical care required by the employees to diagnose, relieve, or cure the effects of the employee's injury. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

The record reflects that all of Petitioner's care and treatment with respect to her heart condition and right knee has been reasonable and necessary. Both of Respondent's examiners, Dr. Nogalski and Dr. Schuman, stipulated to the reasonableness and necessity of Petitioner's care and treatment. Therefore, the Arbitrator finds that the medical treatment rendered to Petitioner has been reasonable and necessary in the quest to cure Petitioner of the effects of her work-related injuries. Based upon the above findings as to accident and causal connection, the Arbitrator finds that Petitioner is entitled to medical benefits. Respondent shall therefore pay the expenses contained in Petitioner's group exhibit 1 as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The law in Illinois holds that "[a]n employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (1990).

Respondent disputed temporary total disability benefits on the basis it disputes accident and causal connection. Based upon the above findings as to accident and causation, the Arbitrator finds Petitioner is entitled to temporary total disability benefits of **$1,138.89**/week for the period **10/8/19 through 11/18/19 and 12/19/19 through 12/23/19**, representing **6-5/7** weeks. Respondent shall be given a credit of $0.00 in TTD benefits.

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

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

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner continues to serve as a Registered Nurse in Respondent's facility performing the same duties as prior to her accident. The Arbitrator places greater weight on this factor.

(iii) **Age**: Petitioner was 48 years old at the time of her injuries. She is younger and has many years over which to live and work with her disability. Pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time), the Arbitrator places greater weight on this factor.

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity contained in the record. The Arbitrator places some weight on this factor.

(v) **Disability**: Petitioner suffered a non-ST elevated myocardial infarction and a right medial knee contusion with proximal gastroc muscle strain injury. Despite the improvement from her treatment, Petitioner testified she has no heat tolerance and has difficulty engaging in activities she enjoyed such as working in her yard and garden, as she easily becomes exhausted. She testified her right knee locks up and gives out on her at times, particularly with prolonged walking or sitting. Petitioner testified she has trouble running to codes at work and has anxiety about having heart troubles again while responding to a code call. She takes Tylenol or Aleve for her knee symptoms and Cardizem for her heart, neither of which she was required to take prior to her work injuries.

The Arbitrator finds Petitioner's testimony regarding her residual complaints consistent with the medical records and the type of injuries she sustained and places greater weight on this factor. Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 10% loss of her body as a whole pursuant to Section 8(d)2 of the Act, and the 5% loss of use of the right knee pursuant to Section 8(e) of the Act.

Linda J. Cantrell, Arbitrator

11/27/20
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC002063
Case Name	MCCANDREW, SHELBI v. STATE OF ILLINOIS/ ALTON MENTAL HEALTH
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0155
Number of Pages of Decision	14
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Aaron Chappell
Respondent Attorney	Caitlin Fiello

DATE FILED: 4/27/2022

/s/ Thomas Tyrrell, 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

McCANDREW, SHELBI,

Petitioner,

vs. NO: 20 WC 02063

SOI/ALTON MENTAL HEALTH,

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 Respondent's Motion for Continuance of Trial to allow for Section 12 Addendum, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 2, 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.

April 27, 2022

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TJT/ldm
051

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0155

McCANDREW, SHELBI
Employee/Petitioner

Case# **20WC002063**

19WC031646

SOI/ALTON MENTAL HEALTH
Employer/Respondent

On 12/2/2020, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY & CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 7
FAIRVIEW HTS, IL 62208

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

0000 ASSISTANT ATTORNEY GENERAL
CAITLIN FIELLO SCHWARTZ
201 W POINTE DR SUITE 7
SWANSEA, IL 62228

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
SPRINGFIELD, IL 62794

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

DEC 2 - 2020

Brendan O Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHELBI MCCANDREW
Employee/Petitioner

v.

STATE OF ILLINOIS/ALTON MENTAL HEALTH
Employer/Respondent

Case # **20-WC-2063**

Consolidated cases: **19-WC-31646**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 28, 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 _____

FINDINGS

On **December 18, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$88,833.16**; the average weekly wage was **$1,708.33**.

On the date of accident, Petitioner was **48** years of age, ***single*** 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 **any benefits paid** under Section 8(j) of the Act.

ORDER

Based on the Arbitrator's decision that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 12/18/19 but remains related to her initial accident on 10/8/19, and the Arbitrator having awarded Petitioner medical expenses, temporary total disability benefits, and permanent partial disability benefits in Case No. 19-WC-31646, the Arbitrator does not award further benefits herein.

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

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

Signature of Arbitrator

11/27/20
Date

DEC 2 - 2020

STATE OF ILLINOIS)
) **SS**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHELBI MCCANDREW,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 20-WC-2063
	)	Consolidated Case No.: 19-WC-31646
STATE OF ILLINOIS/ALTON MENTAL HEALTH,	)	
	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on September 28, 2020. On October 30, 2019, Petitioner filed an Application for Adjustment of Claim alleging injuries to her right knee, chest, heart, and body as a whole as a result of being attacked by a combative patient on October 8, 2019. On January 23, 2020, Petitioner filed an Application for Adjustment of Claim alleging injuries to her right knee as a result of slipping and falling on ice in Respondent's parking lot on December 18, 2019. The cases have been consolidated. The issues in dispute in the present case (Case No. 20-WC-2063) are causal connection, medical bills, temporary total disability benefits, and the nature and extent of Petitioner's injuries. All other issues have been stipulated.

TESTIMONY

Petitioner was 48 years old, single, with two dependent children at the time of the accident. Petitioner testified she has been employed at Respondent's Alton Mental Health facility for three years as a Registered Nurse II. Her job involves caring for patients that are criminally insane and unfit to stand trial. Petitioner's job duties include administering medication, supervising staff, and physically holding or restraining patients. Petitioner testified she worked 16-hour shifts four days per week due to Respondent's overtime mandates.

Petitioner testified that on 10/8/19 she was involved in an altercation with a combative patient. The patient blockaded herself in the bathroom and was banging her head on the bathroom concrete wall. Petitioner and a coworker forced their way into the bathroom, and Petitioner tried to guard the patient from hitting her head or causing further bodily harm. Petitioner was kicked in the right knee and chest, bitten, and spat on by the patient. The patient was 5'11" and very strong and Petitioner had to hold the patient in a burrito wrap until they would get her in the restraint room. Petitioner testified she felt her heart racing during the

incident and initially thought it was just adrenalin. Petitioner subsequently began having difficulty breathing.

Petitioner testified that her coworker, Jason Phillips, was under the sink with her and he noticed Petitioner was in distress and called for assistance to remove Petitioner from the area. Petitioner returned to the nursing station after the incident to tend to patient matters and placed a pulse oximeter on her finger due to her increased heart rate. Petitioner testified that prior to the accident she took Metoprolol for high blood pressure, but she has never had an issue with her heart.

Although there are surveillance cameras throughout the facility, there are no cameras in the restroom where the incident occurred. The surveillance video admitted into evidence by Respondent does contain footage of the door where Petitioner pushed her way inside the restroom. Petitioner testified she reported the incident to her supervisor and filled out an incident report that was consistent with her testimony. A statement was prepared by Ms. Travis who stated Petitioner helped restrain the combative patient and afterwards Petitioner called her to feel her elevated pulse and was eventually taken away by ambulance. Coworker Larry Wylie prepared a statement stating he observed Petitioner and three other employees under the sink getting kicked, scratched, spit on and bitten by the patient. Mr. Wylie was advised that an ambulance was called and he guided the EMTs to where Petitioner was sitting. He noted Petitioner was very pale and the EMTs assessed her O2 level was low, her heart rate was over 200". They applied oxygen and transported Petitioner to St. Anthony's Medical Center.

Respondent's physician on duty, Dr. Yusuf Moyhuddin, also completed an incident report. Petitioner called Dr. Moyhuddin to be assessed following the incident. Dr. Moyhuddin reported that when he arrived, Petitioner was sitting in the kitchen area with a pulse oximetry machine attached to her finger. Petitioner had palpitations and shortness of breath, her heart rate fluctuated between 200 and 220, and he noted Petitioner was in obvious distress. He immediately told her to call an ambulance and go the emergency room. His report notes that Petitioner then contacted control, who in turn called 911. Dr. Mohyuddin reported that Petitioner told him she was involved in a very difficult situation including a complicated patient who needed to be physically restrained and taken to the restraint room. Petitioner reported to him that restraining the patient brought about her fast heart rate, extreme anxiety, shortness of breath, and chest pain. Petitioner denied any symptoms prior to encountering the patient. Dr. Mohyuddin indicated that he called and spoke with the ER physician about Petitioner before EMS arrived to transport her.

The incident report completed by Petitioner's supervisor, Ann Hoffstetter, states that an employee who requested her name remain anonymous accused Petitioner of consuming "some type of substance on 10/8/19 which caused her to have a rapid heart rate." The employee would not tell the reporting personnel what Petitioner consumed or how she knew said information. Petitioner testified that her call to Ann Hoffstetter was not a pleasant phone call and she ended up hanging up on her and then called Dr. Mohyuddin. Petitioner's incident report details her supervisor's expletive laden remarks to her on the phone and later when her supervisor entered the medical room door prior to Dr. Mohyuddin sending her to the emergency room. Ann Hoffstetter was not present to testify at arbitration.

Petitioner testified she initially placed the pulse oximetry on her finger after she called Dr. Mohyuddin and she wore it while continuing her job duties and until EMTs arrived to transport her.

Petitioner testified she was diagnosed with a small heart attack and underwent a cardiac catheter the following morning. Petitioner testified she reported knee pain to the ER physician and he ordered an x-ray. She followed up with her primary care physician who ordered an MRI of her right knee. She was referred to Dr. Becton who prescribed a knee brace and physical therapy. Petitioner was referred to Dr. Saha for her cardiac condition and he performed a cardiac ablation. Petitioner contributed her cardiac condition to stress from the incident and fatigue from mandatory overtime work. Petitioner testified she worked back-to-back 8-hour shifts, lives one hour from work, and only had time for a few hours of sleep before her next 16-hour shift started.

Petitioner testified she was off work from 10/8/19 through 11/18/19. She suffered a second injury to her right knee on December 18, 2019, when she slipped and fell in Respondent's icy parking lot while on her way to an annual CPI class. Petitioner filed a second Application for Adjustment of Claim on 1/23/20 bearing Case No. 20-WC-2063 that was not consolidated but tried simultaneously with the above-captioned case. Petitioner testified that the State owns and maintains the parking lot where she fell on 12/18/19 and stated that the area where she parked was restricted from the general public. There was a light dusting of snow and black ice on the parking lot. Petitioner testified the sidewalks were salted and the parking lot had not been salted where she parked.

Petitioner testified that despite the improvement from her treatment, she has no heat tolerance and has difficulty engaging in activities she enjoyed such as working in her yard and garden, as she easily becomes exhausted. She also testified her right knee locks up and gives out on her at times, particularly with prolonged walking or sitting. She testified she has trouble running to codes at work and has anxiety about having heart troubles again while responding to a code call. She takes Tylenol or Aleve for her knee symptoms. She takes Cardizem for her cardiac condition.

Respondent called Shannon LaPlant as a witness. Ms. LaPlant is Respondent's Workers' Compensation Coordinator and testified she received a Notice of Injury from Petitioner and obtained the video surveillance of the day of accident. Ms. LaPlant confirmed that no surveillance cameras are mounted in restrooms or bedrooms. Ms. LaPlant testified she was able to recognize Petitioner and her coworkers in the surveillance video. She also observed Petitioner wearing the pulse oximetry on her finger. The video depicts Petitioner leaving the doc station and entering the kitchen. Ms. LaPlant testified, however, that she was not present during the incident and did not learn of its occurrence until two or three days later. Ms. LaPlant testified that the report she made was not about the incident itself, but was made at the request of Respondent to report additional details and forms Respondent requested her to gather.

Respondent called Debra Meyer, Clinical Nurse Manager, to testify. Ms. Meyer has been a nurse for 38 years and worked for Respondent since 2014. Ms. Meyer testified that pulse oximetry machines are used to check oxygen saturation for individuals short of breath and detect heart rate. She testified that a rate greater than 100 is classified as high by the American Heart Association. She testified that if the pulse oximetry gave a high reading and a manual heart rate

check corroborated the high reading it would constitute a medical emergency. Ms. Meyer testified that Petitioner is a good employee and she had no reason to believe Petitioner was not honest. Ms. Meyer was not working with Petitioner on the date of Petitioner's incident.

Respondent called Wenter Hurst, a Security Therapy Aide I, to testify. Ms. Hurst testified she entered the bathroom at the same time as Petitioner to restrain the patient. She confirmed that the patient was beating her head against the sink and floor and became aggressive. Ms. Hurst stated the patient would kick, punch, and bite when she was outraged. She believed the patient hit all of the staff, including Petitioner, but did not see the patient kick Petitioner. Ms. Hurst testified that Petitioner did not mention to her that she was out of breath or having a heart attack. Following the incident, Ms. Hurst observed Petitioner on the phone sitting in the doc station. She observed Petitioner to be out of breath. She next saw Petitioner in the kitchen for a few seconds when Petitioner "flopped down" in a chair to rest. Ms. Hurst acknowledged that she and Petitioner were involved in a stressful situation trying to restrain a combative person. She testified that Petitioner was "moving around a lot" and that a code restraint typically requires a lot of constant back and forth to manage the patient and do paperwork. She testified that she was present when the ambulance arrived but did not see Petitioner's transport.

Respondent called Nicole Hinton, a Mental Health Technician, to testify. Ms. Hinton testified she responded to the code call and arrived at the restroom where Petitioner and several others were already engaged in the restraint. She testified she did not see Petitioner get kicked by the patient, nor did she notice Petitioner in distress. She testified that after the incident she next saw Petitioner enter the kitchen and sit down at which time Petitioner was complaining of her supervisor. She observed Petitioner walking and did not notice a limp. She observed Petitioner put the pulse oximetry on her finger and was present when an ambulance was called. Ms. Hinton testified she could not recall whether she prepared a witness report, and she confirmed that Petitioner was already in the restroom dealing with the patient before she arrived. She was aware Petitioner was taken by ambulance but unaware that Petitioner was evaluated by Dr. Mohyuddin prior to her transport. She was further unaware of the nature of Petitioner's injuries or whether Petitioner had any heart problems prior to this accident.

MEDICAL HISTORY

Petitioner was taken via ambulance to Saint Anthony's Health Center, where she was admitted for a chief complaint of rapid heart rate. A history of the patient altercation was recorded, including her knee injury, and it was noted that Petitioner's initial pulse oximetry measured her heart rate in the 220s. By the time Petitioner reached the emergency department her blood pressure remained elevated in the 110s/120s. The attending provider noted Petitioner's manager would not let her leave. It was also noted Petitioner was wheezing, had chest pain, and Petitioner had been working six days a week, 16- hour shifts due to staff shortage, and Petitioner was not getting much sleep. X-rays of Petitioner's chest and an EKG were unremarkable, but Petitioner's labs were positive for elevated troponin at 0.838. Petitioner underwent cardiac catheterization, which demonstrated findings of hyperdynamic left ventricular systolic function, elevated left ventricular filling pressures, and probable uncontrolled hypertension based on the corkscrew nature of the coronary arteries. Clinical impression was non-ST elevated myocardial infarction and tachycardia. Petitioner also reported right knee pain and x-rays were normal.

Petitioner was given Cardizem in addition to the Metoprolol she took for hypertension and instructed to follow up with her primary care physician and the cardiology department.

Petitioner presented to her primary care physician, Dr. Pamela Lowry at Washington County Rural Health, for follow-up care. A consistent history of accident was reported and Petitioner stated she began having chest pains during the altercation. Petitioner used a pulse ox following the incident and noted her heart rate to be 220. She reported she felt like she was going to pass out. She reported she called her supervisor who yelled at her and Petitioner hung up the phone. Petitioner reported that the supervisor came to the med room and proceeded to yell at her. The supervisor told her she herself had the flu and should not be outside of her office. Petitioner reported that the stress at work is extremely high, she hardly gets any sleep when mandated to work double shifts and has to be back the next morning. Petitioner stated she gets off work at 11:00 p.m. and by the time she drives one hour home and gets to bed at 1:00 a.m., she has to get up before 4:30 a.m. in order to report to work by 6:30 a.m. She reported that her work conditions and mandated hours has caused undue stress emotionally, physically, and mentally.

The history further noted that Petitioner developed moderate-to-severe right knee pain after she was kicked by the patient during the altercation. Petitioner described her pain as burning, piercing, sharp, constant, and progressive. Associated symptoms included crepitus and decreased mobility. Petitioner was noted to be tearful when talking about her health and work demands during physical examination. Examination showed mild right knee effusion with maximum tenderness over the right medial joint line, guarded medial McMurray's testing, positive pivot shift testing, and positive valgus stress testing. Dr. Lowry assessed SVT (supraventricular tachycardia) and right medial knee pain. Conservative treatment was recommended, including medication and ice for Petitioner's right knee, and she was taken off work for four weeks.

Petitioner presented to Dr. Marras at Prairie Cardiovascular on 10/24/19. Dr. Marras noted a consistent history of the injury and that Petitioner had several different heart rates. Suspecting that one of the rates may have been different than SVT or that Petitioner may have more than one SVT circuit, he arranged for a 30-day event monitor and referred her to Dr. Saha for consultation for an ablation. Dr. Saha recommended electrophysiology studies (EPS) and catheter ablation.

Petitioner returned to Dr. Lowry on 10/30/19 at which time Petitioner's symptoms progressed to include nocturnal awakening, numbness, popping, clicking, and throbbing pain in the right knee, in addition to crepitus, joint tenderness, and swelling. Petitioner was still experiencing tachycardia and was being monitored by a cardiologist. Physical examination continued to show positive orthopedic testing with maneuvers such as Thessaly's. An MRI was ordered and Ms. Lowry referred Petitioner to Dr. Paletta for further evaluation.

Petitioner underwent cardiac ablation by Dr. Saha at St. Elizabeth's Hospital on 12/19/19. During the procedure, the slow pathway was mapped for electrograms and junctional ectopy was noted. Following the procedure, isoproterenol was transfused to achieve a resting heart rate less than 100 beats per minute. The concluding analysis was successful slow pathway modification, and Petitioner was advised to get rest and continue her home medications.

The right knee MRI was performed on 12/27/19 and she followed up with Dr. Paletta's partner, Dr. Wendell Becton. Dr. Becton noted Petitioner has experienced persistent pain and a feeling of weakness in her right knee since being kicked by a patient on 10/8/19. Dr. Becton noted Petitioner's second right knee injury on 12/18/19 when she slipped on ice and landed directly on her knee. He noted Petitioner's initial treatment of Diclofenac 75 mg which did not improve her pain. The MRI showed mild tendinopathy of the medial gastrocnemius tendon as well as reactive soft tissue and bone marrow edema in that area. Petitioner reported her right knee hurts after standing for long periods of time and when she gets up from a seated position. She denied having any previous right knee surgeries or injuries.

Dr. Becton noted Petitioner had not had physical therapy and found Petitioner's MRI was positive for reactive soft tissue at the medial gastroc muscle area proximally with some tibial marrow edema and mild patellofemoral and medial femoral compartment arthritis. His impression was right medial knee contusion with proximal gastroc muscle strain injury. He prescribed physical therapy, a supportive Kneesio brace, and a medication regimen of Diclofenac and Meloxicam. He allowed Petitioner to return to work but restricted her from overtime for the next 8 weeks.

Petitioner returned to Dr. Becton on 3/24/20 after undergoing some physical therapy at Apex Physical Therapy. Petitioner's therapy was interrupted by the outbreak of COVID-19. Petitioner continued to have pain and tenderness in the medial right knee area. Petitioner felt well enough to return to work. Dr. Becton opined Petitioner's right knee condition was directly work related and desired Petitioner to continue physical therapy. He believed Petitioner would reach maximum medical improvement within two to three months.

Petitioner last saw Dr. Becton via Facetime on 5/12/20 at which time she reported doing well after returning to work, with occasional knee pain rated 2-3 out of 10. He recommended Petitioner continue home knee exercises on a regular basis, advised her to continue using Meloxicam as needed, and lifted her overtime restrictions.

On 2/3/20, Petitioner was examined by Dr. Michael Nogalski pursuant to Section 12 of the Act with respect to her right knee. Dr. Nogalski reviewed the history of accident and Petitioner's medical records and noted Petitioner was kicked by the patient in her right knee. Examination showed generalized tenderness in the medial joint line, medial femoral condyle, and medial tibial plateau. Dr. Nogalski noted residual tenderness with maximal hamstring stretch. His review of the MRI showed broad signal changes in the medial gastroc, indiscriminate bone marrow signal changes along the subchondral zone of the medial tibial plateau, a cyst centrally in the tibia without reactive signal changes around it, and some chondrosis of the medial and patellofemoral compartments. He noted that although a majority of the witness reports focused on her cardiac symptoms, Petitioner's Notice of Injury and medical records indicated she was kicked in her right knee.

Dr. Nogalski believed Petitioner had some preexisting medial patellofemoral chondrosis in her right knee but noted there were some objective findings of signal changes in the medial gastrocnemius. He believed Petitioner may have had some reactive bone marrow edema from the

accident. His assessment was status post right knee contusion and possible gastrocnemius strain either due to a direct blow injury or strain during the altercation of 10/8/19. Dr. Nogalski opined there is a reasonably causal relationship between Petitioner's signal change within the gastrocsoleus area and reported accident. Bone marrow signal issues are somewhat indeterminant and she might have or could have sustained a bone contusion given the type of activities she described in restraining the patient. He further concluded that Petitioner's medical treatment to date was reasonable, including the right knee MRI, to assess and treat her right knee.

On 3/13/20, Petitioner was examined by Dr. Stephen Schuman with respect to her heart condition. Dr. Schuman took a consistent history of the incident, reviewed Petitioner's medical records, and noted Petitioner was sent to the emergency department by Respondent's medic on duty, Dr. Moyhuddin. He also noted that witness reports gave basically similar accounts. Dr. Schuman noted Petitioner's initial heart rate was fluctuating between 200 and 220 and that after her conversion EKG's showed tachycardia in the 130's with occasional premature ventricular contractions (PVCs). After performing his own physical examination which noted objective findings of a normal electrocardiogram and a normal physical examination, Dr. Schuman's assessment was non-ST elevation myocardial infarction on 10/8/19, likely due to coronary artery spasm associated with supraventricular tachycardia. Dr. Schuman opined there is a causal relationship between Petitioner's non-ST elevation myocardial infarction (with associated episode of SVT) and the reported accident. He further concluded that Petitioner's medical treatment to date had been reasonable and necessary, and that necessary additional treatment would include remaining on Cardizem CD (Diltiazem) for prevention of possible coronary artery spasm and prevention of recurring episodes of SVT.

CONCLUSIONS OF LAW

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

Based on the evidence and Petitioner's medical records, the Arbitrator finds that Petitioner's current condition of ill-being in her right knee is not causally related to her subsequent accident that occurred on 12/18/19 but remains related to her initial accident on 10/8/19 (Case No. 19-WC-31646). The record suggests the 12/18/19 accident aggravated Petitioner's symptoms and that neither the character of her symptoms nor her recommended course of treatment was altered as a result thereof. While Petitioner's symptoms increased following the 12/18/19 accident, it is clear the second incident did not sever the chain of causal connection from the first incident. *Lasley Construction Co. v. Industrial Comm'n,* 274 Ill.App.3d 890, 893, 655 N.E.2d 5 (1995) (holding that "other incidents, whether work-related or not, may have aggravated the claimant's condition is irrelevant").

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 decision that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 12/18/19 but remains related to her initial accident on 10/8/19, and the Arbitrator having awarded Petitioner medical expenses in Case No. 19-WC-31646, the Arbitrator does not award further benefits herein.

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

Based on the Arbitrator's decision that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 12/18/19 but remains related to her initial accident on 10/8/19, and the Arbitrator having awarded Petitioner temporary total disability benefits in Case No. 19-WC-31646, the Arbitrator does not award further benefits herein.

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

Based on the Arbitrator's decision that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 12/18/19 but remains related to her initial accident on 10/8/19, and the Arbitrator having awarded Petitioner permanent partial disability benefits with respect to her right knee in Case No. 19-WC-31646, the Arbitrator does not award further benefits herein.

Linda J. Cantrell, Arbitrator

11/27/20
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC011848
Case Name	HUDSON, BRENDA E v. R&L MANAGEMENT CO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0156
Number of Pages of Decision	13
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Crystal Figueroa
Respondent Attorney	Brian Bendoff

DATE FILED: 4/27/2022

/s/Maria Portela, 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

Brenda Hudson,

Petitioner,

vs. NO: 15 WC 011848

R&L Management 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 accident, medical expenses, permanent partial disability, nature & extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 17, 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.

April 27, 2022

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MEP/ypv
049

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUDSON, BRENDA
Employee/Petitioner

Case# **15WC011848**

R&L MANAGEMENT COMPANY
Employer/Respondent

On 6/17/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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.

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

2221 VRDOLYAK LAW GROUP LLC
RACHEL PETER
100 N RIVERSIDE PLZ SUITE 2400
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
BRIAN G BENDOFF
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

B. Hudson v. R & L Mgt. Co., 15 WC011848

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

BRENDA HUDSON
Employee/Petitioner
v.
R&L MANAGEMENT COMPANY
Employer/Respondent

Case # 15 WC 011848

An *Application for Adjustment 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 **November 15, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. Hudson v. R & L Mgt. Co., 15 WC011848

FINDINGS

On **February 26, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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.

The Parties agreed that Petitioner's average weekly wage was **$296.00**.

On the date of accident, Petitioner was **66** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$85.30** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$85.30**.

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

ORDER

Claim for compensation denied, Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on February 26, 2015.

Further, Respondent is ordered to pay the Athletico bill for the FCE ordered and relied upon by its Section 12 Physician, Dr. Mark Levin (dos: 7/20/2015, $922.46.

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

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

Signature of Arbitrator

June 15, 2020
Date

JUN 17 2020

ICArbDec p. 2

STATEMENT OF FACTS

Petitioner was employed by Respondent as a check cashier/clerk cashier. She was so employed for 11 years. Her job duties included cashing checks, processing bill payments, making copies and Western Union transactions. She sat at a counter to wait on customers and got up and walked around and to process transactions. She would also bend in performing her job tasks.

Petitioner testified that, on the date of accident, February 26, 2015, she was "getting ready to get up in the chair" when the chair slipped out from under her. She fell backwards and landed on the ground. Petitioner testified that she hadn't yet begun her shift when the accident occurred. Respondent had recently installed new carpet tile on the floor and it was kind of slippery. The chair was old and raggedy, but it was not defective, according to Petitioner.

On cross examination, Petitioner described the chair as a "swivel office chair, adjustable." The chair had wheels. Petitioner stated on cross examination that the wheels on the chair were without defect. Petitioner agreed that the chair functioned properly. The height of the chair was described by Petitioner as being 24 inches.

With respect to her injuries, Petitioner testified that she initially believed she had "busted her ribs" as a result of falling from her chair. She testified that "[i]t wasn't no little bitty fall." She testified that her coworkers wanted to send her to a nearby hospital, Jackson Park Hospital. However, she refused this care and requested her adult son pick her up to take her to Advocate Christ Hospital. Petitioner testified she had a preference for Advocate Christ Hospital.

Petitioner agreed on cross-examination that she told her physicians a consistent history of her seat slipping out from under her. Petitioner said that she told her "primary" physician that new carpeting contributed to the accident. Petitioner, however, subsequently admitted that she had no reason to dispute that she "told her primary care physician that ... [her] chair simply slipped as [she] was attempting to get onto it." (Tr. Pg. 44). The PCP physician's records contain no mention of any problem with the carpet that contributed to the fall. (PX 2)

With regard to what injuries she noted immediately after the fall, Petitioner testified she felt pain in her shoulders bilaterally and in her back. In addition, she testified that "my coworker said I hit my head, but I couldn't remember anything". (Tr. Pg. 16) Petitioner testified that her accident was seen by two coworkers whom she did not refer to by name, but described as "the two ladies that were there". (Tr. Pg 17)

Petitioner was first seen in the emergency department at Advocate Christ Medical Center on February 26, 2015. The history was that the patient reported a mechanical fall while trying to sit at work and a chair slipped out from under her. Petitioner reported pain in the left shoulder, lower back, and ribs. She was prescribed ibuprofen, was provided a sling to wear for her left arm. She was discharged with instructions to return as needed. No work restriction was provided. (PX 1)

Petitioner was asked on direct examination if she recalled following up at Advocate Medical Group on March 2, 2015. She testified in response, "That was my birthday. I can't remember." (Tr. Pg. 19). She did not dispute that the record reflected that she had followed up on this date. Petitioner's Exhibit 2 shows that Petitioner followed up at AMG on March 2, 2015 and March 18, 2015. At the March 2, 2015 visit, he was seen s/p fall and reported that she slipped off a chair at work. Petitioner complained of anterior ribcage pain and low back pain. She denied any neurologic problems. There were no shoulder complaints. A physical examination was performed and no significant findings were recorded aside from an unrelated lipoma on petitioner's upper back. Petitioner was diagnosed with multiple trauma, hypertension, diabetes and sinusitis. She was prescribed ibuprofen, Cyclobenzaprine and an antibiotic for an unrelated cold. She was told to return as needed. At the March 18, 2015 visit, Petitioner complained of back pain, right shoulder pain and pain across the top of her stomach. She had no recent falls, but was anxious about climbing a stool at work. The diagnosis was multiple trauma and the treatment plan was observation. Petitioner was given an Ex-Post-Facto off work note (2/26/2015 until further notice) and was to return, PRN. (PX 2)

On direct examination, Petitioner testified that she did not dispute she treated Christ Medical Center, Advocate Medical Center, Dr. Ossama Abdellatif, Chiropractors Carlos Halwaji and Saoud Dabbah, and Dr.

James Diesfield (Tr. Pg. 19-23). Petitioner also testified to undergoing treatment at Athletico, also known at the time as Accelerated Rehabilitation. The records of Petitioner's medical treatment from these physicians, and records of the bills in relation to the same, were entered into evidence as Petitioner's Exhibits 1-9.

On April 13, 2015, Petitioner underwent treatment at Midwest Neurodiagnostic Specialists. Chiropractor Carlos Halwaji was the treating physician at this location. On this date, Petitioner complained of pain in the neck, mid and lower back, as well as numbness and tingling in her arms and legs. Petitioner reported a history of falling to the floor while in the process of sitting on a chair when it slipped out from under her. Dr. Halwaji reviewed Petitioner's cervical MRI findings and noted a C5-6 postsurgical fusion, as well as disc bulging at C3 through T1. On physical examination, Petitioner had tenderness with spasm in her neck and back. She was also noted to have decreased range of motion in her arms, legs, neck, and back. Chiropractor Halwaji performed an EMG/NCV on this date, and determined via this test that petitioner had radiculitis affecting the C7-T1 and L4-S1 levels bilaterally. Chiropractor Halwaji did not recommend a treatment plan on this date. (PX 7)

On April 23, 2015, Petitioner underwent an initial chiropractic evaluation at Burbank Medical Center. Chiropractic physician Dr. Saoud Dabbah was the evaluating physician. The records reflect that Petitioner treated with this provider regularly between April 23, 2015 and October 13, 2015. Petitioner attended over twenty chiropractic appointments with Dr. Dabbah. The records are handwritten, and the initial records indicate Petitioner sustained injuries after falling off a chair at work. Dr. Dabbah noted that Petitioner had treated at this facility previously. Petitioner's initial complaints included pain in the mid and lower back and right shoulder. Dr. Dabbah treated Petitioner sporadically and provided off-work notes from April 23, 2015 through June 16, 2015. (PX 4)

Petitioner testified on direct examination that she underwent an independent medical examination with Dr. Mark Levin on June 4, 2015. (Tr. Pg. 22, RX 1) On cross-examination, several minutes after agreeing she underwent an examination by Dr. Levin, Petitioner was asked to confirm the same. Petitioner testified as follows:

"Q: In July of 2015, do you recall seeing a doctor at the request of your employer?

A: July of what?
Q: July of 2015, a Dr. Levin?
A: No.
Q: You don't recall seeing Dr. Levin?
A: I don't even recall the name, no.
Q: On direct examination –
A: I'm trying to think – July, we are going back five years. (Tr. 42-43).

Petitioner subsequently recalled the examination, but required several verbal cues prior to her recollection. Of course, **Petitioner's testimony is correct. She was examined by Dr. Levin in June of 2015.** Per the IME report of Dr. Mark Levin, an orthopedic surgeon, Petitioner reported a history of accident of sitting on a rolling stool and the stool fell out from under her. She reported falling to the floor. Dr. Levin noted this occurred on February 26, 2015. Petitioner reported to Dr. Levin that she had fallen a year earlier. She had a lawsuit pending with respect to that fall, and had treated with the same chiropractic group. She reported that her lawyer referred her to the chiropractic group. Petitioner testified on cross-examination that she sustained a slip and fall accident in January of 2014, approximately one year prior to the 2015 fall from her chair (Tr. Pg. 39). Petitioner testified that she filed suit against Circle K as a result of that accident (Tr. Pg. 40). Petitioner confirmed that she treated with Dr. Dabbah as a result of that accident (Tr. Pg 39). Petitioner reported to Dr. Levin that she had treated with Dr. Dabbah due to a motor vehicle accident as well. (R X1)

During the independent medical examination on June 4, 2014, Petitioner reported complaints were that she felt pain in multiple areas including her right shoulder, low back and neck. She reported significant limitations. Petitioner reported that she used a cane at times. She admitted that the cane had not been prescribed by a doctor and it was used electively. She reported taking pain medication, anti-inflammatories, and muscle relaxers. She reported pain levels in her shoulders of up to 8 out of a possible 10, lumbar spine pain up to a 10 and neck pain at a 6 out of a possible ten.

Dr. Levin noted that the physical examination reflected inconsistences. Dr. Levin reported that Petitioner walked with an exaggerated, side-to-side and slow gait during the examination. Dr. Levin noted this be a different gait than observed when Petitioner exited the examination room. Petitioner complained of tenderness over

multiple body parts, but Dr. Levin noted Petitioner did not have any significant objective findings in the neck, low back or shoulder. Dr. Levin noted no spasm over the cervical paraspinal muscles, bilaterally. No muscle spasm was noted over the lumbosacral junction or over the buttocks. Petitioner had normal active range of motion in the shoulders, bilaterally. Dr. Levin's examination of Petitioner's lower extremities resulted in "moaning and groaning out-of-proportion to testing." (RX 1)

Dr. Levin obtained x-rays of Petitioner, which were negative but for what he deemed to be degenerative changes unrelated to the fall of February 26, 2015. Dr. Levin reviewed MRIs of Petitioner's cervical spine, right shoulder, and lumbar spine. He noted tendinitis in petitioner's right shoulder, degenerative changes of the cervical spine as well as a fusion of the C5-C6 level and he noted the diagnostics of petitioner's lumbar spine were unremarkable. (RX 1)

Dr. Levin concluded that Petitioner had "marked subjective complaints of pain over multiple areas, which are out-of-proportion to objective findings. Dr. Levin noted Petitioner's records listed injuries to body parts that differed from the history she provided regarding her fall and the described injuries. Dr. Levin further observed that Petitioner had inconsistent clinical records, as well as subjective complaints which could not be related to pathology related to her fall on February 26, 2015. He further concluded that Petitioner required no additional treatment. Dr. Levin recommended that Petitioner undergo a Functional Capacity Examination to determine if work restrictions were necessary. (RX 1)

Petitioner underwent an FCE at Accelerated Rehabilitation on July 20, 2015. (PX 5) The FCE reflected Petitioner's job required a capability of performing sedentary tasks. The FCE was noted to be invalid due to an inconsistent performance by Petitioner. A sedentary duty restriction was recommended. (PX 5) Apparently, Respondent did not pay the bill for the FCE, which was sent to Petitioner. (PX 8) This is even though the study was recommended by Respondent's examining doctor and he relied upon it in his addendum report. (RX 2)

On July 31, 2015, Dr. Levin authored an addendum to his IME report. He reviewed records from Dr. Dabbah, Dr. Halwaji, and Dr. Abdellatif. He reviewed Petitioner's FCE report. Dr. Levin concluded that

Petitioner was capable of performing nearly her entire job, per the findings of the invalid FCE, despite only 47% reliable responses. Dr. Levin concluded Petitioner was at maximum medical improvement and recommended she return to work in a full duty capacity. Furthermore, Dr. Levin concluded that she had received "excessive treatment modalities," required no additional treatment, and stated that Petitioner was not a surgical candidate. (RX 2)

With respect to a return to work, Petitioner testified she did not return to work after her February 26, 2015 accident. (Tr. 44-45) On cross-examination, Petitioner aggreed that no doctor had ever permanently restricted her from working (Tr. Pg. 45) Petitioner testified that she did not apply for work after her February 26, 2015 work accident through the date of the hearing due to an unrelated sickness. (Tr. Pg. 52) Petitioner did submit off work slips, said to show medically authorized lost time from 2/26/2015 through 6/16/2015.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Statement of Facts in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between her employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)).

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

In support of the Arbitrator's decision relating to (C), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, the Arbitrator finds:

Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on February 26, 2015.

It is undisputed that Petitioner's fall took place on Respondent's premises shortly before she started her work day. The injury therefore occurred in the course of her employment by Respondent.

It is on the issue of "arising out of" that Petitioner's claim fails. An injury arises out of a claimant's employment where it "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the injury." Sisbro v. Industrial Comm'n, 207 Ill. 2d 193, 203 (2003) Without proving the number of times that Petitioner would sit on the chair during her work day, or that the 24 inch high chair was defective in some way, or that Respondent's premises was defective (new carpet tile, but no showing that it contributed to Petitioner's fall), there is no showing that there was a risk of injury connected with Petitioner's employment. Accordingly, the injury did not arise out of Petitioner's employment.

The Claim for Compensation is, therefore, DENIED.

The Arbitrator notes that the McAllister v. Workers' Compensation Comm'n, 2019 IL APP (1st) 162747WC is under consideration by the Illinois Supreme Court. Perhaps the holding in McAllister will provide guidance on the arising out of issue on review.

In support of the Arbitrator's decision relating to (F), Is Petitioner's current condition of ill-being causally related to the injury?, (J), Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; (K) What temporary benefits are in dispute? (TTD); and (L) What is the nature and extent of the injuries?, the Arbitrator finds:

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent, the Arbitrator needs not decide the above issues.

Respondent is ordered to pay the Atletico bill for the FCE, which was ordered by its IME physician, Dr. Mark Levin. The amount of the bill is $922.46 and it is contained in PX 8.