ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC025787
Case Name	AGBEMAVOR, AFIWA A v. JBS USA INC FKA CARGILL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0389
Number of Pages of Decision	17
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Jason Payne

DATE FILED: 8/2/2021

DISSENT

/s/ Deborah Simpson, 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AFIWA AGBEMAVOR,

Petitioner,

vs. NO: 17 WC 25787

JBS,

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 the nature and extent of Petitioner's permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner worked for Respondent trimming chicken breasts using scissors and processing the pieces. She developed conditions of ill-being of her right hand and right thumb. Petitioner filed three Applications for Adjustment of Claim, which were consolidated at arbitration. The Arbitrator found that Petitioner proved a compensable, repetitive trauma, accident and causation in all these claims. In 17 WC 25786, he awarded Petitioner 10.25 weeks of permanent partial disability benefits representing loss of the use of 5% of the right hand. That decision was not reviewed. In 17 WC 25787, he awarded Petitioner 30.75 weeks of permanent partial disability benefits representing loss of 15% of the right hand after her reaggravation of extensor tenosynovitis. In 19 WC 18475 he awarded Petitioner 7.6 weeks of permanent partial disability benefits representing loss of 10% of the use of the right thumb. No Petition for Review was filed in 17 WC 25786. Claim 19 WC 18475 is being affirmed and adopted in a separate Opinion and Decision on Review.

On February 18, 2016, after the second injury to Petitioner's right hand/wrist, Dr. Maender performed right wrist extensor tensynovectomy with lengthening of the extensor retinaculum and repair of the middle-finger extensor tendon for extensor tenosynovitis with fraying and partial tearing of the extensor tendon of the middle finger. Petitioner had physical therapy through September 23, 2016, at which time Dr. Meander released her to work without restrictions. On November 9, 2016, Dr. Meander noted that Petitioner had tolerated her return to work, declared her at maximum medical improvement, released from treatment, and continued her full-duty status.

Petitioner testified that currently, her right hand is weak, and she has to use her left hand to assist her right while working. She used to use mostly her right hand but now her left hand was stronger than her right. Every evening after work, she has to use hot water and biofreeze before she goes to bed. She has pain every day and occasional swelling where her thumb meets her wrist. She continued to work her job bagging/boxing/trimming.

Dr. Fletcher was retained by Respondent to prepare an impairment rating based on AMA Guides. He noted that Petitioner reported right-hand swelling/burning/aching which was currently rated as 2/10, with associated right hand swelling, burning, and aching. The pain was constant and higher when she got off work. The pain is also worse in cold weather. Her Quick DASH score was 22.7 connoting mild subjective disability "consistent with Functional Grade Modifier of 1." In his clinical examination, Dr. Fletcher noted considerable weakness in Petitioner's right-hand grip. Although she was right-hand dominant, her left-hand grip was much stronger than her right. In three measurements, her left grip was assessed at 65, 70, and 80, while her right-hand grip was assessed as 25, 20, 15, respectively.

Dr. Fletcher's diagnoses were status post right wrist extensor tensynovectomy with lengthening of the extensor retinaculum and repair of the middle-finger extensor tendon and resolved deQuervain's syndrome. deQuervain's syndrome was the condition of ill-being alleged in claim 19 WC 18475, which is being affirmed in a separate decision. Dr. Fletcher summarized treatment. He assessed the "wrist ruptured muscle/tendon residual loss, functional with normal motion Defaults to Grade C or 5% Upper Extremity Impairment." There was no objective findings regarding the wrist sprain (deQuervain's) which translated to a 0% Upper Extremity Impairment.

As noted above, in this claim the Arbitrator awarded Petitioner 30.75 weeks of permanent partial disability benefits representing loss of 15% of the right hand. In his analysis of Petitioner's permanent partial disability, the Arbitrator gave moderate weight to the AMA impairment rating provided by Dr. Fletcher, he gave greater weight to Petitioner's return to her physically strenuous job. He gave significant weight to Petitioner's age (41) which indicated she would have a working life of about 20 years in the strenuous job. He gave little weight to Petitioner's potential loss of future earnings because she was in her previous job. Finally, the Arbitrator gave significant weight to evidence of disability in the record citing her consistent complaints, which matched the AMA impairment rating report prepared by Dr. Fletcher.

The Commission agrees generally with the weight the Arbitrator gave to the statutory factors to assess permanent partial disability. However, we believe those factors point to a

somewhat higher permanency award. In particular, the Commission notes the extreme difference in Petitioner's grip strength. It appears from Dr. Fletcher's examination, that Petitioner's left-hand grip was more than three and a half times stronger than her dominant right-hand grip. The Commission believes that this factor should be given greater weight. In addition, Dr. Fletcher's AMA impairment rating of loss of 5% of the right arm is a relatively large permanency assessment for a hand/wrist injury. In looking at the entire record before us, the Commission finds an award of 51.15 weeks representing loss of the use of 25% of the right hand is appropriate in this claim and modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $377.79 per week for a period of 51.25 weeks because the work injury resulted in the permanent loss of 25% the use her the right hand pursuant to §8(e) of the Act.

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

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

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

August 2, 2021

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

DLS/dw
O-7/13/21
46

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

Dissent

I respectfully dissent from the majority. In my opinion, the Arbitrator correctly applied the statutory criteria, placed the correct weight to those factors, and arrived at a reasonable and adequate permanency award for the injuries Petitioner sustained. Therefore, I would have affirmed and adopted the Decision of the Arbitrator in its entirety.

Neither the Majority, nor even the Petitioner, apparently have specific issues with the weight the Arbitrator placed on the statutory factor, rather they apply similar weight to those

factors as the Arbitrator but simply arrive at a higher permanency award. Not only do I agree with the Arbitrator's analysis of the statutory factors, the Arbitrator was in a position to observe Petitioner personally during the arbitration hearing. Not only does the Arbitrator's personal observation of Petitioner as a witness help him/her assess the claimant's credibility, it also assists the Arbitrator is assessing the claimant's overall level of disability. In this instance, I see no reason to disturb the Decision of the Arbitrator.

For these reasons I would have affirmed and adopted the Decision of the Arbitrator in its entirety. Therefore, I respectfully dissent from the Decision of the Majority.

/s/*Deborah L. Simpson*

DLS/dw

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0389

AGBEMAVOR, AFIWA
Employee/Petitioner

Case# **17WC025787**

17WC025786
19WC018475

JBS
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:

5354 STEPHEN P KELLY ATTY AT LAW
MATTHEW A BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

2461 NYHAN BAMBRICK KINZIE & LOWRY
JASON H PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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
NATURE AND EXTENT ONLY

Afiwa Agbemavor
Employee/Petitioner

v.

JBS
Employer/Respondent

Case # **17** WC **25787**

Consolidated cases: **17 WC 25786; 19 WC 18475**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **9/29/2020**. By stipulation, the parties agree:

On the date of accident, **10/15/15**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$32,741.80**, and the average weekly wage was **$629.65**.

At the time of injury, Petitioner was **41** years of age, ***single*** with **1** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$377.79**/week for a further period of **30.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **15% loss of use of the right hand**.

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

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

Carl Lee
Signature of Arbitrator

11/23/20
Date

DEC 2 - 2020

FINDINGS OF FACT

The Petitioner has worked for the Respondent for over 14 years. Her first two years she worked a whizard knife position on second shift. For the last 12 year plus she has been working on the same line boxing, bagging, and trimming cushions. The cushion is a portion of a pork shoulder.

This process involves trimming skin, fat and bone from the cushion and throwing the cushions into a combo. The Petitioner uses scissors the do the trimming. The Petitioner holds the scissors in her right hand to do the trimming. Petitioner is right hand dominant. When she bags the cushions, the Petitioner places five cushions in each bag. Each cushion weighs between 5-7 pounds. One bag weighs 23 pounds and she fills up a bag every three seconds. Petitioner will fill approximately 500 bags per shift. The amount bags filed a day will vary depending on the seasons and the amount of orders the facility receives.

The Petitioner has worked 8-10 hours a day, 5-6 days a week for the Respondent over the last 14 plus years. The Petitioner began to develop symptoms in her right hand in approximately 2012-2013. She noticed pain and numbness in her fingers along with swelling on the top portion of her right hand. The Petitioner was placed on light duty and her symptoms went away, but when she returned to the cushion job her symptoms returned.

The Petitioner initially presented to MOHA on 5/21/14. The Petitioner complained of swelling over the back of her right hand. The Petitioner noted that she had been doing a lot of bagging. She does a variety of things on her line, but she has been doing a lot of bagging recently. The Petitioner had swelling and pain with palpation of the swollen of area and flexion of the wrist. The Petitioner was diagnosed with tendonitis. She was given a cool comfort splint and a Prednisone treatment. She was also placed on light duty specifically limiting her lifting of heavy boxes that is required in her position. (PX 2)

The Petitioner followed up on 6/10/14 with MOHA. She had continued complaints of swelling of the dorsum of her right hand. The Petitioner did note improvement following her Prednisone treatment and her light duty restrictions. Diagnosis remained dorsal hand swelling and pain. The Petitioner was put into formal physical therapy and her restrictions were lifted to see if she could progress of using tools only one hour a day and be able to lift 35 lbs. The Petitioner followed up on 6/27/14. At that time it was recommended she transition back to her regular job and she was to follow up in two weeks. (PX 2)

The Petitioner did participate in physical therapy at Apex from 6/12/14 through 6/26/14.

The Petitioner followed up with MOHA on 7/8/14. The Petitioner was feeling much better and noted she was on a 50% reduced count. She believed she could return to work full duty. She was to continue moist heat and lodine as needed and she was returned to work full duty and discharged from care as of 7/8/14. (PX 2)

The Petitioner returned to MOHA on 9/30/14. The Petitioner described her job as bag/box cushion. She does not utilize a knife but she does bag and box products. The Petitioner again complained of swelling in her right dorsal wrist and hand predominantly of the region of the mid-ulnar wrist and fourth metacarpal region. Her pain does wax and wane. The Petitioner was diagnosed with right hand extensor tendon sheath edema. The Petitioner was again given a course of Prednisone as well as Relafen. An x-ray was ordered. The Petitioner was placed on light duty and was to limit grasping with the right hand. She was also given a compression glove. (PX 2)

On 10/1/14 the Petitioner presented to Passavant Area Hospital for right hand x-rays. There was no evidence of fracture, dislocation or bony destructive change. (PX 3)

On 10/14/14 the Petitioner returned to MOHA. It was noted that following the Petitioner's return to work at full duty in July of 2014 her symptoms recurred. At this time the Petitioner was again diagnosed with dorsal right wrist and hand pain with persistent swelling. The Petitioner was to continue Relafen and light duty and a recommendation was made for referral to a hand specialist. (PX 3)

On 11/11/14 the Petitioner was examined by Dr. Richard Brown at the Springfield Clinic. Dr. Brown noted the Petitioner complained of right hand swelling and pain. The Petitioner was on steroids and stated that did provide her some relief. X-rays were normal. Dr. Brown diagnosed the Petitioner with extensor tenosynovitis and believed that the Petitioner's use of scissors at work contributed to her condition. Dr. Brown also suspected that there may be a more systemic problem potentially a rheumatoid factor and Petitioner should have a rheumatologic evaluation. Dr. Brown discussed a tenosynovectomy but was not convinced that this would solve the problem. It was recommended that the Petitioner undergo bloodwork to determine her rheumatoid factor and encouraged light duty with no use of scissors. (PX 13)

The Petitioner was seen at Culbertson Memorial Hospital on 11/18/14 for the rheumatologic evaluation. The rheumatological studies were within the normal limits and the Petitioner's ANA was negative. (PX 4)

The Petitioner returned to MOHA on 12/9/14. The Petitioner still complained of pain in her right dorsal hand region and she was still on light duty. Restrictions were amended so that she would only have to perform a 25% count. An additional recommendation for an orthopedic consultation regarding her right hand extensor tendon sheath edema was made. (PX 2)

The Petitioner was next seen by Dr. Maender at the Orthopedic Center of Illinois on 12/17/14. The Petitioner had complaints of right wrist pain. The Petitioner is right hand dominant. Dr. Maender took a history of the medical care the Petitioner had underwent and performed an examination. Diagnosis of acute right wrist pain was made. Dr. Maender recommended to try a steroid injection to see if this would resolve the Petitioner's complaints. If this was not successful then she would be a candidate for a fourth extensor tenosynovectomy and exploration of the extensors to prevent fraying of the tendons. An injection was administered and the Petitioner indicated she was ready to wean back into work and doing a gradual return to work with 15 minutes off every hour. (PX 5)

The Petitioner followed up with Dr. Maender on 1/9/15. The injection provided at the previous visit did help decrease her pain. Still having pain off and on with use of the hand. The Petitioner has returned to work without any restrictions and is doing her normal duties. Dr. Maender recommended continued observation and regular anti-inflammatories. Dr. Maender recommended the Petitioner continue to work without restrictions and to follow up in six weeks for re-evaluation. (PX 5)

The Petitioner was seen at MOHA on 2/9/15 by Dr. Gordon. Dr. Gordon was to continue to evaluate the Petitioner's work status. It was discussed that the Petitioner was able to perform her job of box/cushion meat so long as she does not have to utilize scissors. The scissors are the part of her job which seem to aggravate her symptoms. The Petitioner had done well up to this point and it was not anticipated for any other treatment beyond conservative care and appropriate placement. The Petitioner was to continue with Mobic and would have an additional follow up appointment with Dr. Maender in March of 2015. The Petitioner was to continue full duty except no use of scissors as well a 15% reduced piece count. (PX 2)

The Petitioner saw Dr. Maender again on 3/9/15. The Petitioner reported that the previous injection had helped resolve her symptoms and she has been working full duty and has been doing well. The Petitioner denied

pain or swelling in the hand. At this time the Petitioner was released to return to work without restrictions and placed at maximum medical improvement.

Petitioner returned to the cushion job at that time. At first the Petitioner was doing good, but over the summer into the fall of 2015 her symptoms returned.

The Petitioner later saw MOHA again on 10/15/15. The Petitioner reported that she did well for approximately four months but then her swelling came back again gradually. The Petitioner reports that she was performing the boxing and bagging meat job. The Petitioner had done this job before but had not had any prior issue with this part of the job. The Petitioner felt that her issues were due to the use of scissors and she had not been using scissors recently. The Petitioner had been on light duty for the past two weeks and her symptoms improved somewhat. Diagnosis was right wrist/hand fourth dorsal compartment tenosynovitis which was recurrent. Dr. Gordon's note from this date indicates that this matter was not a new condition and is a function of a prior issue for which she underwent an injection by Dr. Maender. (PX 2)

An additional injection was offered which the Petitioner declined at this time. The Petitioner requested to be re-evaluated for definitive management of this condition and Dr. Gordon recommended with Dr. Maender. The Petitioner was placed on light duty work with limited grasping with the right hand. (PX 2)

The Petitioner saw Dr. Maender again on 11/4/15. The Petitioner that her symptoms returned when she returned to work full duty. The Petitioner was again diagnosed with extensor tenosynovitis of the right wrist. This was felt to be recurrent. Dr. Maender was concerned of tearing of the extensor tendon. An MRI of the right wrist was recommended. If MRI showed significant tenosynovitis the Petitioner would require an extensor tenosynovectomy and possible repair of the extensor tendon or transfers depending upon the quality. The Petitioner was continued on light duty restrictions with follow up after the MRI. (PX 5)

The Petitioner underwent an MRI of the right wrist at Culbertson Memorial Hospital on 11/8/15. This study showed mild tenosynovitis extensor digitorum as well as the extensor carpi radialis brevis and extensor carpi radialis longus; intact appearing scapholunate and TFCC. (PX 6)

Dr. Maender next saw the Petitioner on 1/6/16. Dr. Maender reviewed the MRI with the Petitioner. The Petitioner indicated that she is "back on the line" and the tenosynovitis has redeveloped. Pain and swelling was noted at the dorsal wrist. The Petitioner had popping and grinding with use of the hand. At this point Dr. Maender recommended surgical exploration and extensor tenosynovectomy. (PX 5)

On 2/18/16 the Petitioner underwent a right wrist extensor tenosynovectomy with lengthening of the extensor retinaculum and repair of the middle finger extensor tendon. This was performed by Dr. Maender. Post-operative diagnosis was right wrist extensor tenosynovitis with fraying and partial tearing of the extensor tendon of the middle finger. The Petitioner was returned to work with no use of the right arm following surgery. (PX 8)

The Petitioner followed up with Dr. Maender on 3/2/16 following surgery. The Petitioner was still requiring pain medication but she was out of her splint. Swelling was noted but the Petitioner denied any numbness and tingling. An additional splint fabrication was ordered and the Petitioner was recommended to begin physical therapy. Restrictions were continued of no use of the right hand.

The Petitioner underwent physical therapy at Apex physical therapy following her surgery from 3/8/16 through 6/16/16. (PX 14)

The Petitioner followed up with Dr. Maender on 4/11/16. The Petitioner continued to have right wrist swelling and pain. She complained on incomplete flexion of the index finger and limited wrist mobility. Swelling was localized to the dorsal wrist and hand. The Petitioner had been working on retrograde massage and with therapy. Dr. Maender the Petitioner formed significant scar tissue around the surgical site. Dr. Maender believed that this was the primary reason for her limited range of motion and the fact that she still had significant pain. The Petitioner was to continue with therapy and retrograde massage. Anti-inflammatories were recommended as well as a steroid injection around the area of the swelling to help with pain and inflammation. Restrictions were continued of no use of the right hand. An injection of the fourth dorsal compartment tendon sheath on the right at this time. (PX 5)

The Petitioner followed up with Dr. Maender on 5/11/16. The Petitioner's motion was improving with therapy. She still had soreness. Swelling had improved. Dr. Maender noted that the mild swelling was improved from previous examination after her injection. The Petitioner continued to lack wrist flexion secondary to extrinsic tightness. Scar tissue had formed around the surgical which is the main reason for continued for limited motion most notably in wrist flexion. The Petitioner was to continue with therapy and recommended continued use of anti-inflammatories. Restrictions included no lifting more than 5 lbs with her right hand and to follow up in four weeks. (PX 5)

The Petitioner next saw Dr. Maender on 6/13/16. The Petitioner continued to have pain in the wrist with range of motion. Pain mostly along the index and middle finger. This was along the extensor surface. No pain when the wrist is in neutral position and it is only when her wrist is flexed and her fingers are flexed that she notices pain. Dr. Maender noted improved hypersensitivity and early chronic regional pain syndrome. The Petitioner had made significant improvements especially with regard to her pain but still has extensor tightness. Recommend continued therapy and a suggestion was made to potentially send the Petitioner to a certified hand therapist to help regarding her complaints. Work restrictions were issued of no repetitive gripping with the right hand. Following this visit Dr. Maender did recommend the Petitioner switch from physical therapy to certified hand therapy. (PX 5)

The Petitioner participated in certified hand therapy at Memorial Medical Center from 6/23/16 through 9/23/16. (PX 10)

The Petitioner followed up with Dr. Maender on 7/13/16. It was noted that following the switch to the certified hand therapist did have improvement. Pain had improved as well as her swelling. Some tightness of the index and middle finger was noted but it was improved. Continuing to use brace and splinting. The Petitioner was to continue physical therapy at this time and was to also continue with the same work restrictions. (PX 5)

The Petitioner followed up with Dr. Maender on 8/24/16. Wrist continued to improve. The Petitioner still has pain with her wrist most notably with motion. Therapy has made great progress with her. The Petitioner's extensor tightness is significantly improved. The Petitioner is to continue with ongoing therapy. Goal is to maximize her motion and strength. Restrictions continued of no repetitive with the right hand and was to follow up in one month. (PX 5)

Dr. Maender next saw the Petitioner on 9/26/16. The Petitioner had no complaints of redness or swelling. Slight pain noted with wrist up and down movement. The Petitioner had good range of motion with the wrist and fingers. The Petitioner had been taking Tylenol for pain. Motion was noted to be much improved. No evidence of residual extrinsic tightness. The Petitioner was to return to work full duty at this time to see how she would tolerate that. If the Petitioner is able to tolerate her return to work at full duty she we will be placed at maximum medical improvement at the next visit. (PX 5)

The Petitioner next saw Dr. Maender on 11/9/16. The Petitioner was doing well and was happy with her results. The Petitioner had tolerated her return to work. The Petitioner did have a small amount of wrist pain once she returned to work. Takes Tylenol on occasion has good range of motion in her wrist in fingers. Dr. Maender continued the Petitioner to continue to work at full duty and placed her at maximum medical improvement as of 11/9/16. The Petitioner was to follow up as needed. (PX 5)

The Petitioner again returned to work full duty in the cushion job. The Petitioner stayed in that position through January 2018. In early 2018 she began to notice a recurrence of swelling, a lot of pain, and specifically had difficulty using the scissors to do the trimming.

The Petitioner returned to MOHA on 1/4/18. The Petitioner described performing her job as cushions, basically trimming cushions, boxing cushions and bagging cushions. The Petitioner indicated she had been utilizing scissors more than normal over the pre-holiday time frame. The Petitioner indicated that her right wrist had been hurting for at least the couple of weeks and that she occasionally does have to lift 60lb items. The Petitioner was diagnosed with right deQuervain's syndrome. The Petitioner was recommended to try a soft neoprene cool comfort splint for her right wrist. The Petitioner was to continue to take NSAIDs over the counter. The Petitioner was to continue to work full duty at this time. (PX 5)

The Petitioner returned to MOHA on 1/11/18. The Petitioner indicated that she does own the job of bag cushion meat. With this job she does have to bag the product and also has to trim the product with scissors. The product that she processes is approximately 3-5lbs. The Petitioner has been utilizing her splint but it has not provided her much relief. The Petitioner was prescribed Prednisone as well as was provided restrictions. Recommendation was that the Petitioner be cautioned with regard to her right upper extremity on the production line. If the Petitioner had continued symptoms at the time of her follow up they would discuss doing an injection. (PX 2)

The Petitioner was again seen by MOHA on 1/25/18. The Petitioner reported the Prednisone was helpful. However the Petitioner did have ongoing complaints of pain at 3 out of 10 in the region of the first dorsal compartment. The Petitioner was diagnosed with overall improved right deQuervain's syndrome but still symptomatic. At this time a corticosteroid injection was performed in the right first dorsal compartment. The Petitioner described the injection resolving her pain. The Petitioner was again recommended to utilize caution at her workplace which was her restriction as of this date. (PX 2)

The Petitioner was next seen by MOHA on 2/14/18. The Petitioner reported that the injection previously performed was helpful. The Petitioner had been using Ibuprofen rarely. A discussion was had regarding the job that she owns. The Petitioner does own the bag and box cushions job which requires to her to trim the cushions utilizing scissors when necessary. Again it was noted that the tasks with these scissors bother her the most. The Petitioner was asked to demonstrate how she utilizes the scissors by Dr. Gordon. The Petitioner indicated that scissors are not always necessary but when certain orders require the utilization of scissors she may use them for a good portion of the day. Dr. Gordon had a discussion with the Petitioner and her supervisor Larry Carter to discuss different job opportunities for her. A discussion was had about looking at the "box necks" position and also the "DNG" job. These jobs do not require the utilization of a knife or scissors. The Petitioner was discharged from care without any permanent restrictions as of 2/14/18. (PX 2)

The Petitioner was later seen by an AMA impairment rating at the request of the Respondent by Dr. David Fletcher. This examination took place on 4/25/18. The Petitioner had continued right hand swelling, burning and aching. Pain was noted to be a 2 out of 10. The Petitioner reported she has constant right hand pain which worsens after getting off of work as well as in cold weather. No numbness or tingling was noted. The Petitioner

did complete a Quick Dash rating which showed that her score was 22.7 which is mild self-reported disability consistent with a functional grade modifier of 1.

Dr. Fletcher the Petitioner with status post right wrist extensor tenosynovectomy, lengthening of the extensor retinaculum and repair of middle finger extensor tendon on 2/18/16. Dr. Fletcher also diagnosed resolved deQuervain's syndrome.

On examination Dr. Fletcher noted slight swelling of the dorsum of the wrist. No other positive exam findings were noted. Dr. Fletcher also reviewed the Petitioner's medical records including the operative report by Dr. Maender.

The Petitioner was noted by Dr. Fletcher to be right hand dominant. The Petitioner's grip strength on the right on position 2 resulted in scores of 25, 20 and 15. On the Petitioner's non-dominant left hand her grip scoring in position 2 correlated to 65, 70 and 80. Dr. Fletcher issued a final PPI rating of 5% of the upper extremity.

At the time of trial Petitioner testified that her right hand is weak. She drops things and has to use her non-dominant left hand for many more tasks than before her accidents manifested themselves. Petitioner testified her left hand is stronger than her right. This is supported by Dr. Fletchers AMA report. The Petitioner has pain daily and uses hot water and BioFreeze to help with the pain. She at times notices swelling at the base of her thumb.

Permanent Partial Disability with 8.1b language (For injuries after 9/1/11)

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. The Respondent admitted at the time of trial an AMA rating report by Dr. David Fletcher. Dr. Fletcher noted right hand swelling, burning and aching. The Petitioner had a 2 out of 10 pain level. The Petitioner was diagnosed with status post 2/18/16 right wrist extensor tenosynovectomy, lengthening of the extensor retinaculum, repair of the middle finger extensor tendon and resolved DeQuervain's syndrome. The Petitioner had slight swelling of the dorsum of the wrist. Dr. Fletcher also noted significant loss of grip strength on the right hand. The Arbitrator notes the Petitioner is right hand dominant. For the five position grip test results per Dr. Fletcher's AMA rating on the right she scored 25, 20 and 15. Whereas on the left, which is her non-dominant hand she scored 65, 70 and 80. His overall impairment rating was 5% of the right upper extremity. The Arbitrator gives moderate rate to this factor

With respect to factor (ii), the occupation of the injured employee, Petitioner performed the job of trimming, boxing and bagging 5-7 lbs. of pork shoulder (cushions) at the time of the accidents. Following the injuries to her right hand and right thumb, she returned to the same job. Petitioner testified that she can perform the duties of the job and that she has not been placed on any work restrictions. The Arbitrator finds this to be strenuous work and for these reasons gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 39, 41 and 43 years old at the time of the accidents. The Petitioner has a work life expectancy of over 20 years for this type of work. The Arbitrator, therefore, gives this significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner has not suffered any loss to her earning capacity. The Petitioner has received raises that all of the Respondent's employees receive each year. The Arbitrator therefore gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner has had consistent complaints to her right hand in both the medical records and her testimony at the time of the trial. These complaints also match the AMA report issued by Dr. Fletcher. This Arbitrator therefore gives this significant weight.

17 WC 25787 - 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 15% loss of use of the right hand pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC018475
Case Name	AGBEMAVOR, AFIWA A v. JBS USA
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0390
Number of Pages of Decision	14
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Jason Payne

DATE FILED: 8/2/2021

/s/ Deborah Simpson, 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

Afiwa Agbemavor,
Petitioner,

vs. NO: 19 WC 18475

JBS,
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 nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 2, 2021

o7/13/21
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
NOTICE OF ARBITRATOR DECISION

AGBEMAVOR, AFIWA
Employee/Petitioner

Case# **19WC018475**

17WC025786
17WC025787

JBS
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:

5354 STEPHEN P KELLY ATTY AT LAW
MATTHEW A BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

2461 NYHAN BAMBRICK KINZIE & LOWRY
JASON H PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Afiwa Agbemavor
Employee/Petitioner

v.

JBS
Employer/Respondent

Case # **19** WC **18475**

Consolidated cases: **17 WC 25786; 17 WC 25787**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee,** Arbitrator of the Commission, in the city of **Springfield**, on **9/29/2020**. By stipulation, the parties agree:

On the date of accident, **11/23/17**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$36,044.11**, and the average weekly wage was **$693.15**.

At the time of injury, Petitioner was **43** years of age, ***single*** with **1** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$415.89**/week for a further period of **7.6** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of use of the thumb**.

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

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

Signature of Arbitrator

11/23/20
Date

DEC 2 - 2020

FINDINGS OF FACT

The Petitioner has worked for the Respondent for over 14 years. Her first two years she worked a whizard knife position on second shift. For the last 12 year plus she has been working on the same line boxing, bagging, and trimming cushions. The cushion is a portion of a pork shoulder.

This process involves trimming skin, fat and bone from the cushion and throwing the cushions into a combo. The Petitioner uses scissors the do the trimming. The Petitioner holds the scissors in her right hand to do the trimming. Petitioner is right hand dominant. When she bags the cushions, the Petitioner places five cushions in each bag. Each cushion weighs between 5-7 pounds. One bag weighs 23 pounds and she fills up a bag every three seconds. Petitioner will fill approximately 500 bags per shift. The amount bags filed a day will vary depending on the seasons and the amount of orders the facility receives.

The Petitioner has worked 8-10 hours a day, 5-6 days a week for the Respondent over the last 14 plus years. The Petitioner began to develop symptoms in her right hand in approximately 2012-2013. She noticed pain and numbness in her fingers along with swelling on the top portion of her right hand. The Petitioner was placed on light duty and her symptoms went away, but when she returned to the cushion job her symptoms returned.

The Petitioner initially presented to MOHA on 5/21/14. The Petitioner complained of swelling over the back of her right hand. The Petitioner noted that she had been doing a lot of bagging. She does a variety of things on her line, but she has been doing a lot of bagging recently. The Petitioner had swelling and pain with palpation of the swollen of area and flexion of the wrist. The Petitioner was diagnosed with tendonitis. She was given a cool comfort splint and a Prednisone treatment. She was also placed on light duty specifically limiting her lifting of heavy boxes that is required in her position. (PX 2)

The Petitioner followed up on 6/10/14 with MOHA. She had continued complaints of swelling of the dorsum of her right hand. The Petitioner did note improvement following her Prednisone treatment and her light duty restrictions. Diagnosis remained dorsal hand swelling and pain. The Petitioner was put into formal physical therapy and her restrictions were lifted to see if she could progress of using tools only one hour a day and be able to lift 35 lbs. The Petitioner followed up on 6/27/14. At that time it was recommended she transition back to her regular job and she was to follow up in two weeks. (PX 2)

The Petitioner did participate in physical therapy at Apex from 6/12/14 through 6/26/14.

The Petitioner followed up with MOHA on 7/8/14. The Petitioner was feeling much better and noted she was on a 50% reduced count. She believed she could return to work full duty. She was to continue moist heat and lodine as needed and she was returned to work full duty and discharged from care as of 7/8/14. (PX 2)

The Petitioner returned to MOHA on 9/30/14. The Petitioner described her job as bag/box cushion. She does not utilize a knife but she does bag and box products. The Petitioner again complained of swelling in her right dorsal wrist and hand predominantly of the region of the mid-ulnar wrist and fourth metacarpal region. Her pain does wax and wane. The Petitioner was diagnosed with right hand extensor tendon sheath edema. The Petitioner was again given a course of Prednisone as well as Relafen. An x-ray was ordered. The Petitioner was placed on light duty and was to limit grasping with the right hand. She was also given a compression glove. (PX 2)

On 10/1/14 the Petitioner presented to Passavant Area Hospital for right hand x-rays. There was no evidence of fracture, dislocation or bony destructive change. (PX 3)

On 10/14/14 the Petitioner returned to MOHA. It was noted that following the Petitioner's return to work at full duty in July of 2014 her symptoms recurred. At this time the Petitioner was again diagnosed with dorsal right wrist and hand pain with persistent swelling. The Petitioner was to continue Relafen and light duty and a recommendation was made for referral to a hand specialist. (PX 3)

On 11/11/14 the Petitioner was examined by Dr. Richard Brown at the Springfield Clinic. Dr. Brown noted the Petitioner complained of right hand swelling and pain. The Petitioner was on steroids and stated that did provide her some relief. X-rays were normal. Dr. Brown diagnosed the Petitioner with extensor tenosynovitis and believed that the Petitioner's use of scissors at work contributed to her condition. Dr. Brown also suspected that there may be a more systemic problem potentially a rheumatoid factor and Petitioner should have a rheumatologic evaluation. Dr. Brown discussed a tenosynovectomy but was not convinced that this would solve the problem. It was recommended that the Petitioner undergo bloodwork to determine her rheumatoid factor and encouraged light duty with no use of scissors. (PX 13)

The Petitioner was seen at Culbertson Memorial Hospital on 11/18/14 for the rheumatologic evaluation. The rheumatological studies were within the normal limits and the Petitioner's ANA was negative. (PX 4)

The Petitioner returned to MOHA on 12/9/14. The Petitioner still complained of pain in her right dorsal hand region and she was still on light duty. Restrictions were amended so that she would only have to perform a 25% count. An additional recommendation for an orthopedic consultation regarding her right hand extensor tendon sheath edema was made. (PX 2)

The Petitioner was next seen by Dr. Maender at the Orthopedic Center of Illinois on 12/17/14. The Petitioner had complaints of right wrist pain. The Petitioner is right hand dominant. Dr. Maender took a history of the medical care the Petitioner had underwent and performed an examination. Diagnosis of acute right wrist pain was made. Dr. Maender recommended to try a steroid injection to see if this would resolve the Petitioner's complaints. If this was not successful then she would be a candidate for a fourth extensor tenosynovectomy and exploration of the extensors to prevent fraying of the tendons. An injection was administered and the Petitioner indicated she was ready to wean back into work and doing a gradual return to work with 15 minutes off every hour. (PX 5)

The Petitioner followed up with Dr. Maender on 1/9/15. The injection provided at the previous visit did help decrease her pain. Still having pain off and on with use of the hand. The Petitioner has returned to work without any restrictions and is doing her normal duties. Dr. Maender recommended continued observation and regular anti-inflammatories. Dr. Maender recommended the Petitioner continue to work without restrictions and to follow up in six weeks for re-evaluation. (PX 5)

The Petitioner was seen at MOHA on 2/9/15 by Dr. Gordon. Dr. Gordon was to continue to evaluate the Petitioner's work status. It was discussed that the Petitioner was able to perform her job of box/cushion meat so long as she does not have to utilize scissors. The scissors are the part of her job which seem to aggravate her symptoms. The Petitioner had done well up to this point and it was not anticipated for any other treatment beyond conservative care and appropriate placement. The Petitioner was to continue with Mobic and would have an additional follow up appointment with Dr. Maender in March of 2015. The Petitioner was to continue full duty except no use of scissors as well a 15% reduced piece count. (PX 2)

The Petitioner saw Dr. Maender again on 3/9/15. The Petitioner reported that the previous injection had helped resolve her symptoms and she has been working full duty and has been doing well. The Petitioner denied

pain or swelling in the hand. At this time the Petitioner was released to return to work without restrictions and placed at maximum medical improvement.

Petitioner returned to the cushion job at that time. At first the Petitioner was doing good, but over the summer into the fall of 2015 her symptoms returned.

The Petitioner later saw MOHA again on 10/15/15. The Petitioner reported that she did well for approximately four months but then her swelling came back again gradually. The Petitioner reports that she was performing the boxing and bagging meat job. The Petitioner had done this job before but had not had any prior issue with this part of the job. The Petitioner felt that her issues were due to the use of scissors and she had not been using scissors recently. The Petitioner had been on light duty for the past two weeks and her symptoms improved somewhat. Diagnosis was right wrist/hand fourth dorsal compartment tenosynovitis which was recurrent. Dr. Gordon's note from this date indicates that this matter was not a new condition and is a function of a prior issue for which she underwent an injection by Dr. Maender. (PX 2)

An additional injection was offered which the Petitioner declined at this time. The Petitioner requested to be re-evaluated for definitive management of this condition and Dr. Gordon recommended with Dr. Maender. The Petitioner was placed on light duty work with limited grasping with the right hand. (PX 2)

The Petitioner saw Dr. Maender again on 11/4/15. The Petitioner that her symptoms returned when she returned to work full duty. The Petitioner was again diagnosed with extensor tenosynovitis of the right wrist. This was felt to be recurrent. Dr. Maender was concerned of tearing of the extensor tendon. An MRI of the right wrist was recommended. If MRI showed significant tenosynovitis the Petitioner would require an extensor tenosynovectomy and possible repair of the extensor tendon or transfers depending upon the quality. The Petitioner was continued on light duty restrictions with follow up after the MRI. (PX 5)

The Petitioner underwent an MRI of the right wrist at Culbertson Memorial Hospital on 11/8/15. This study showed mild tenosynovitis extensor digitorum as well as the extensor carpi radialis brevis and extensor carpi radialis longus; intact appearing scapholunate and TFCC. (PX 6)

Dr. Maender next saw the Petitioner on 1/6/16. Dr. Maender reviewed the MRI with the Petitioner. The Petitioner indicated that she is "back on the line" and the tenosynovitis has redeveloped. Pain and swelling was noted at the dorsal wrist. The Petitioner had popping and grinding with use of the hand. At this point Dr. Maender recommended surgical exploration and extensor tenosynovectomy. (PX 5)

On 2/18/16 the Petitioner underwent a right wrist extensor tenosynovectomy with lengthening of the extensor retinaculum and repair of the middle finger extensor tendon. This was performed by Dr. Maender. Post-operative diagnosis was right wrist extensor tenosynovitis with fraying and partial tearing of the extensor tendon of the middle finger. The Petitioner was returned to work with no use of the right arm following surgery. (PX 8)

The Petitioner followed up with Dr. Maender on 3/2/16 following surgery. The Petitioner was still requiring pain medication but she was out of her splint. Swelling was noted but the Petitioner denied any numbness and tingling. An additional splint fabrication was ordered and the Petitioner was recommended to begin physical therapy. Restrictions were continued of no use of the right hand.

The Petitioner underwent physical therapy at Apex physical therapy following her surgery from 3/8/16 through 6/16/16. (PX 14)

The Petitioner followed up with Dr. Maender on 4/11/16. The Petitioner continued to have right wrist swelling and pain. She complained on incomplete flexion of the index finger and limited wrist mobility. Swelling was localized to the dorsal wrist and hand. The Petitioner had been working on retrograde massage and with therapy. Dr. Maender the Petitioner formed significant scar tissue around the surgical site. Dr. Maender believed that this was the primary reason for her limited range of motion and the fact that she still had significant pain. The Petitioner was to continue with therapy and retrograde massage. Anti-inflammatories were recommended as well as a steroid injection around the area of the swelling to help with pain and inflammation. Restrictions were continued of no use of the right hand. An injection of the fourth dorsal compartment tendon sheath on the right at this time. (PX 5)

The Petitioner followed up with Dr. Maender on 5/11/16. The Petitioner's motion was improving with therapy. She still had soreness. Swelling had improved. Dr. Maender noted that the mild swelling was improved from previous examination after her injection. The Petitioner continued to lack wrist flexion secondary to extrinsic tightness. Scar tissue had formed around the surgical which is the main reason for continued for limited motion most notably in wrist flexion. The Petitioner was to continue with therapy and recommended continued use of anti-inflammatories. Restrictions included no lifting more than 5 lbs with her right hand and to follow up in four weeks. (PX 5)

The Petitioner next saw Dr. Maender on 6/13/16. The Petitioner continued to have pain in the wrist with range of motion. Pain mostly along the index and middle finger. This was along the extensor surface. No pain when the wrist is in neutral position and it is only when her wrist is flexed and her fingers are flexed that she notices pain. Dr. Maender noted improved hypersensitivity and early chronic regional pain syndrome. The Petitioner had made significant improvements especially with regard to her pain but still has extensor tightness. Recommend continued therapy and a suggestion was made to potentially send the Petitioner to a certified hand therapist to help regarding her complaints. Work restrictions were issued of no repetitive gripping with the right hand. Following this visit Dr. Maender did recommend the Petitioner switch from physical therapy to certified hand therapy. (PX 5)

The Petitioner participated in certified hand therapy at Memorial Medical Center from 6/23/16 through 9/23/16. (PX 10)

The Petitioner followed up with Dr. Maender on 7/13/16. It was noted that following the switch to the certified hand therapist did have improvement. Pain had improved as well as her swelling. Some tightness of the index and middle finger was noted but it was improved. Continuing to use brace and splinting. The Petitioner was to continue physical therapy at this time and was to also continue with the same work restrictions. (PX 5)

The Petitioner followed up with Dr. Maender on 8/24/16. Wrist continued to improve. The Petitioner still has pain with her wrist most notably with motion. Therapy has made great progress with her. The Petitioner's extensor tightness is significantly improved. The Petitioner is to continue with ongoing therapy. Goal is to maximize her motion and strength. Restrictions continued of no repetitive with the right hand and was to follow up in one month. (PX 5)

Dr. Maender next saw the Petitioner on 9/26/16. The Petitioner had no complaints of redness or swelling. Slight pain noted with wrist up and down movement. The Petitioner had good range of motion with the wrist and fingers. The Petitioner had been taking Tylenol for pain. Motion was noted to be much improved. No evidence of residual extrinsic tightness. The Petitioner was to return to work full duty at this time to see how she would tolerate that. If the Petitioner is able to tolerate her return to work at full duty she we will be placed at maximum medical improvement at the next visit. (PX 5)

The Petitioner next saw Dr. Maender on 11/9/16. The Petitioner was doing well and was happy with her results. The Petitioner had tolerated her return to work. The Petitioner did have a small amount of wrist pain once she returned to work. Takes Tylenol on occasion has good range of motion in her wrist in fingers. Dr. Maender continued the Petitioner to continue to work at full duty and placed her at maximum medical improvement as of 11/9/16. The Petitioner was to follow up as needed. (PX 5)

The Petitioner again returned to work full duty in the cushion job. The Petitioner stayed in that position through January 2018. In early 2018 she began to notice a recurrence of swelling, a lot of pain, and specifically had difficulty using the scissors to do the trimming.

The Petitioner returned to MOHA on 1/4/18. The Petitioner described performing her job as cushions, basically trimming cushions, boxing cushions and bagging cushions. The Petitioner indicated she had been utilizing scissors more than normal over the pre-holiday time frame. The Petitioner indicated that her right wrist had been hurting for at least the couple of weeks and that she occasionally does have to lift 60lb items. The Petitioner was diagnosed with right deQuervain's syndrome. The Petitioner was recommended to try a soft neoprene cool comfort splint for her right wrist. The Petitioner was to continue to take NSAIDs over the counter. The Petitioner was to continue to work full duty at this time. (PX 5)

The Petitioner returned to MOHA on 1/11/18. The Petitioner indicated that she does own the job of bag cushion meat. With this job she does have to bag the product and also has to trim the product with scissors. The product that she processes is approximately 3-5lbs. The Petitioner has been utilizing her splint but it has not provided her much relief. The Petitioner was prescribed Prednisone as well as was provided restrictions. Recommendation was that the Petitioner be cautioned with regard to her right upper extremity on the production line. If the Petitioner had continued symptoms at the time of her follow up they would discuss doing an injection. (PX 2)

The Petitioner was again seen by MOHA on 1/25/18. The Petitioner reported the Prednisone was helpful. However the Petitioner did have ongoing complaints of pain at 3 out of 10 in the region of the first dorsal compartment. The Petitioner was diagnosed with overall improved right deQuervain's syndrome but still symptomatic. At this time a corticosteroid injection was performed in the right first dorsal compartment. The Petitioner described the injection resolving her pain. The Petitioner was again recommended to utilize caution at her workplace which was her restriction as of this date. (PX 2)

The Petitioner was next seen by MOHA on 2/14/18. The Petitioner reported that the injection previously performed was helpful. The Petitioner had been using Ibuprofen rarely. A discussion was had regarding the job that she owns. The Petitioner does own the bag and box cushions job which requires to her to trim the cushions utilizing scissors when necessary. Again it was noted that the tasks with these scissors bother her the most. The Petitioner was asked to demonstrate how she utilizes the scissors by Dr. Gordon. The Petitioner indicated that scissors are not always necessary but when certain orders require the utilization of scissors she may use them for a good portion of the day. Dr. Gordon had a discussion with the Petitioner and her supervisor Larry Carter to discuss different job opportunities for her. A discussion was had about looking at the "box necks" position and also the "DNG" job. These jobs do not require the utilization of a knife or scissors. The Petitioner was discharged from care without any permanent restrictions as of 2/14/18. (PX 2)

The Petitioner was later seen by an AMA impairment rating at the request of the Respondent by Dr. David Fletcher. This examination took place on 4/25/18. The Petitioner had continued right hand swelling, burning and aching. Pain was noted to be a 2 out of 10. The Petitioner reported she has constant right hand pain which worsens after getting off of work as well as in cold weather. No numbness or tingling was noted. The Petitioner

did complete a Quick Dash rating which showed that her score was 22.7 which is mild self-reported disability consistent with a functional grade modifier of 1.

Dr. Fletcher the Petitioner with status post right wrist extensor tenosynovectomy, lengthening of the extensor retinaculum and repair of middle finger extensor tendon on 2/18/16. Dr. Fletcher also diagnosed resolved deQuervain's syndrome.

On examination Dr. Fletcher noted slight swelling of the dorsum of the wrist. No other positive exam findings were noted. Dr. Fletcher also reviewed the Petitioner's medical records including the operative report by Dr. Maender.

The Petitioner was noted by Dr. Fletcher to be right hand dominant. The Petitioner's grip strength on the right on position 2 resulted in scores of 25, 20 and 15. On the Petitioner's non-dominant left hand her grip scoring in position 2 correlated to 65, 70 and 80. Dr. Fletcher issued a final PPI rating of 5% of the upper extremity.

At the time of trial Petitioner testified that her right hand is weak. She drops things and has to use her non-dominant left hand for many more tasks than before her accidents manifested themselves. Petitioner testified her left hand is stronger than her right. This is supported by Dr. Fletchers AMA report. The Petitioner has pain daily and uses hot water and BioFreeze to help with the pain. She at times notices swelling at the base of her thumb.

Permanent Partial Disability with 8.1b language (For Injuries after 9/1/11)

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. The Respondent admitted at the time of trial an AMA rating report by Dr. David Fletcher. Dr. Fletcher noted right hand swelling, burning and aching. The Petitioner had a 2 out of 10 pain level. The Petitioner was diagnosed with status post 2/18/16 right wrist extensor tenosynovectomy, lengthening of the extensor retinaculum, repair of the middle finger extensor tendon and resolved DeQuervain's syndrome. The Petitioner had slight swelling of the dorsum of the wrist. Dr. Fletcher also noted significant loss of grip strength on the right hand. The Arbitrator notes the Petitioner is right hand dominant. For the five position grip test results per Dr. Fletcher's AMA rating on the right she scored 25, 20 and 15. Whereas on the left, which is her non-dominant hand she scored 65, 70 and 80. His overall impairment rating was 5% of the right upper extremity. The Arbitrator gives moderate rate to this factor

With respect to factor (ii), the occupation of the injured employee, Petitioner performed the job of trimming, boxing and bagging 5-7 lbs. of pork shoulder (cushions) at the time of the accidents. Following the injuries to her right hand and right thumb, she returned to the same job. Petitioner testified that she can perform the duties of the job and that she has not been placed on any work restrictions. The Arbitrator finds this to be strenuous work and for these reasons gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 39, 41 and 43 years old at the time of the accidents. The Petitioner has a work life expectancy of over 20 years for this type of work. The Arbitrator, therefore, gives this significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner has not suffered any loss to her earning capacity. The Petitioner has received raises that all of the Respondent's employees receive each year. The Arbitrator therefore gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner has had consistent complaints to her right hand in both the medical records and her testimony at the time of the trial. These complaints also match the AMA report issued by Dr. Fletcher. This Arbitrator therefore gives this significant weight.

19 WC 18475 - 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 10% loss of use of the right thumb pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC035482
Case Name	RODRIGUEZ, CELESTINO v. L & M CORRUGATED
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0391
Number of Pages of Decision	13
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	David Feuer
Respondent Attorney	Paul Schumacher

DATE FILED: 8/2/2021

/s/ Kathryn Doerries, 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 strike sentence from Arb. dec	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CELESTINO RODRIGUEZ,

Petitioner,

vs. NO: 08 WC 35482

L & M CORRUGATED,

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 causal connection, temporary total disability, medical expenses, and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with changes noted herein.

The Commission strikes from the Arbitrator's decision, on page 5, paragraph 4, the second sentence, beginning with "Dr. Erickson…" and ending with, "Petitioner."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2019 is, otherwise, hereby, affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 2, 2021

o- 7/27/21
KAD/jsf

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

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

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

RODRIGUEZ, CELESTINO Case# **08WC035482**
Employee/Petitioner

L & M CORRUGATED
Employer/Respondent

On 12/12/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN FISHMAN BENDER ETAL
DAVID Z FEUER
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0445 EVANS & DIXON LLC
PAUL W SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CELESTINO RODRIGUEZ
Employee/Petitioner

v.

L & M CORRUGATED
Employer/Respondent

Case # **08** WC **35482**

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Waukegan**, on **October 29, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **05/12/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being subsequent to October 20, 2008 ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**28,970.24**; the average weekly wage was $**557.12**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **3** dependent children.

Petitioner ***has not*** 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 $**5,199.74** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**5,199.74**.

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

ORDER

Respondent shall pay Petitioner $371.41 per week for a period of 14 weeks as Petitioner was temporarily and totally disabled commencing 7/15/08 through 10/20/08. Respondent shall receive credit for amounts paid. ARB EX 1.

Respondent shall pay Petitioner $334.27 per week for a period of 50 weeks as Petitioner sustained 10% loss of use of the man as a whole pursuant to Section 8(d)2 of the Act. All PPD has accrued.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred with the care and treatment of Petitioner's causally related condition through October 20, 2008 pursuant to Sections 8 and 8.2 of the Act and subject to RX 7. Respondent shall receive credit for amounts paid and/or subject to RX 7. SEE DECISION

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. O'Neal

Signature of Arbitrator

12/11/19
Date

DEC 12 2019

FINDINGS OF FACT

The Arbitrator initially notes that the matter was presented for trial before a different Arbitrator on July 23, 2015 in its assigned Waukegan venue. The matter was bifurcated at that time. The parties appeared to close proofs before this Arbitrator on October 29, 2019.

At trial on July 23, 2015, Petitioner, Celestino Rodriguez, testified via interpreter that on May 12, 2008, he worked for the Respondent L & M Corrugated as a machine operator. The parties stipulated that Petitioner sustained a work related accident on May 12, 2008. ARB EX 1. On May 12, 2008, Petitioner climbed a stack of cardboard so that he could start his machine. Petitioner testified that he climbed five to six feet and then fell landing on the cement floor. Petitioner testified that the landed on his low back near the waist area. He testified that his co-workers helped him get up and he went back to work. Petitioner testified that he worked a few weeks thereafter but testified that during that time he was "not able to walk" and that he was not able to turn his neck. He testified that he had pain in his low back near the waist and in the neck area. T. 17.

Petitioner first sought treatment from his family doctor, Dr. Yoro and then he sought treatment from Dr. Chhabria on referral from Dr. Yoro. T. 17. Thereafter, Petitioner treated at Marque Medicos and from there he was referred for treatment to Drs. Sclamberg, Ross, and Erickson. Petitioner underwent injections and physical therapy followed by two surgeries performed by Dr. Erickson. T. 18. Petitioner was returned to work on June 10, 2013. However, he testified that he did not return to work for Respondent. Rather, he worked at Giordano's making pizza. T. 20. Petitioner testified that he worked part time for Giordano's at 17-25 hours per week. He testified that he was unable to find work with any other employer but that he would like to work 40 hours per week. T. 21.

Petitioner testified that while at work in the kitchen at Giordano's he stands while preparing the pizza. He does not perform any heavy lifting. He does not take pain medication. Petitioner testified that he currently experiences numbness in his left leg from the ankle to the hip while he is standing. He also feels pain in the left leg and his low back which he can alleviate by doing exercises. He testified that he is unable to bend as he feels a pinching sensation. He feels the two surgeries helped in that before the surgeries he could barely walk. T. 24. Petitioner testified that he had not sought medical treatment since his release in 2013 because he had "no money." T. 25.

On cross-exam, Petitioner also testified that on referral from Marque Medicos, he saw Drs. Ivankovich and Sokolowski. T. 27. Petitioner agreed that the only doctor who recommended surgery was Dr. Erickson. He further recalled Dr. Ross telling him that he was a high risk for a bad surgical outcome due to significant nonorganic symptomatology. T. 32. He testified that he has applied for jobs with full time work but that he presents his restrictions and does not get hired. T. 34. He further agreed that in September 2009, before his surgeries, he performed lawn care and landscaping work for a "man that gives me work once in awhile." T. 34. He testified that he carried mulch in a cart and spread the mulch with his hands. T. 35. He also used a gas operated leaf blower and weed trimmer which he carried. T. 36-37. He also worked in a garden on his knees and using a shovel to pull weeds. He was required to bend to pull the weeds. T. 38. He testified that at the time of trial he was also doing landscaping and yard work if someone called him to help. He testified that he would perform landscaping work up to four days per week. T. 39.

Petitioner was seen by Drs. Yoro and Chhabria and then referred to Marque Medicos for treatment. Petitioner underwent an MRI of his lumbar spine on 7/9/08. The MRI indicated a posterocentral annular tear at L3-4 with a 3 MM disc protrusion in addition to a left neural foraminal protrusion causing moderate left neural foraminal

stenosis with mild central canal narrowing; 3 mm broad based central disc protrusion at L4-5 with broad based annular disc bulge more prominent towards the right side; broad based right paracentral 3 mm disc protrusion at L5-S1; grade I anterolisthesis of L3 on L4. PX 3. Petitioner also underwent an EMG on July 11, 2008 which indicated electrophysiologic evidence of acute denervation of L4 and L5 nerve roots via the finding of the needle examination. There was no evidence of a peripheral entrapment or polyneuropathy. PX 3. Petitioner was treated conservatively with physical therapy, injection and chiropractic treatment through Marque Medicos. At the request of the Respondent, Petitioner was evaluated by Dr. Kern Singh pursuant to Section 12 of the Illinois Worker's Compensation Act. The claimant was first seen on October 20, 2008. RX 3. Dr. Singh testified via evidence deposition. RX 3. Dr. Singh testified that, after taking a history from the petitioner, reviewing medical records, and performing a physical examination, Petitioner's current symptoms were not causally related to his work related injuries sustained on May 12, 2008. Specifically, Dr. Singh reviewed the MRI films dated July 9, 2008 and determined it showed normal alignment of the back and a slight loss of signal intensity at L4-5. RX 3, p. 8. He reviewed an EMG from July 11, 2008, which revealed acute denervation at the L4-5 level. However, he testified that the EMG was fraught with a high level of false positivity. He explained that Petitioner did not report any leg pain to him and therefore no ongoing radiculopathy. He reported back pain only. In addition, the EMG reports an L4-5 radiculopathy but "if we look at the pathology of disk degeneration at L4-5, it's impossible for it to hit the L4 and the L5 nerve root." P. 9-10. He further found positive Waddell signs indicating no anatomic basis necessarily for the patient's pain as it relates to those examination maneuvers." P. 11. Dr. Singh testified that he was concerned by the examination in that Petitioner's perception of pain was extremely heightened. He reported seven to eight out of ten pain in his neck and lower back but no leg pain. He reported being unable to move or ambulate but showed full strength on exam. Dr. Singh opined that Petitioner suffered lumbar muscular strain and degenerative disk disease L4-5 preexisting with no causal connection to Petitioner's employment. P. 8, 12.

The claimant was re-evaluated by Dr. Singh on February 17, 2010. At that time, surgery in the form of a laminectomy and fusion with instrumentation was the recommended treatment by Petitioner's treating doctors, Ivankovich and Sokolowski. Petitioner reported intense low back pain 10 out of 10 traveling down his left leg with no relief to Dr. Singh. P. 14. Dr. Singh performed a clinical exam and noted full leg strength and normal reflexes. He reviewed a CT myelogram from February 2, 2009 which indicated a central disk protrusion with mild bilateral foraminal narrowing consistent with the prior MRI as well as minimal stenosis of the L5-S1 level. He testified that he evaluated the myelogram to determine whether spondylolisthesis was present as was diagnosed by other doctors. He did not observe that condition. He noted positive Waddell findings on exam and observed Petitioner as he moved without any apparent discomfort despite 10/10 pain complaints. P. 16. He testified that based on the lack of objective findings on the MRI or CT myelogram, the normal exam and observed movement, Dr. Singh was unable to explain Petitioner's high pain complaints. P. 17,24.

It was again Dr. Singh's opinion following this second IME that Petitioner's current symptoms are not causally related to the petitioner's work related injury. Dr. Singh disagreed with the surgical treatment recommended and stated that it was not indicated. He placed Petitioner at MMI and opined that he was capable of returning to work without restrictions. P. 18.

Dr. Singh's deposition was taken on April 17, 2014, after Petitioner underwent two surgeries to his low back in 2011 and 2012. Dr. Singh was not persuaded by the reported success of the foraminotomies in that he did not believe the surgeries were physically indicated. Dr. Singh opined that he would have recommended anti inflammatory medications at treatment. P. 21. Dr. Singh opined that any type of surgical fusion was not acceptable for the petitioner. He again opined that the claimed symptoms did not correlate with an anatomic basis and Dr. Singh did believe that the patient would be worse off after spinal surgical intervention. Dr. Singh specifically opined that there was no evidence of instability in any of the radiographic reports or in any of

petitioner's examination findings that would support fusion surgery. At the time of this examination, Petitioner had minimal evidence of stenosis, right greater than left, yet, petitioner's symptoms were all left-sided. Once again, Dr. Singh opined that this emphasized a nonanatomic basis for the petitioner's symptoms.

Well prior to undergoing surgeries in 2011 and 2012, and after Petitioner's 2008 initial evaluation with Dr. Singh, Respondent obtained surveillance video of Petitioner in September 2009. RX 1. Petitioner testified that he performed landscaping work during this time and the video in fact depicts Petitioner working as a landscaper. Specifically, Petitioner is depicted actively moving, bending, stretching, croutching, and reaching while operating a weed cutter, leaf blower and riding mower, all without any pain display. Petitioner's movements are quick and without any hesitation. Petitioner is seen bending and reaching into the back seat of his small car to take out the weed trimmer and what look to be gas cans . The maneuver is awkward given the size of the car but Petitioner has no difficulty performing the bending, reaching, croutching and stretching to retrieve and then replace the weed trimmer from his car or while performing any of the landscaping activity seen on the video. RX 1.

On September 9, 2011, Petitioner underwent a foraminotomy and discectomy at L5-S1 and a foraminotomy at L4-5 performed by Dr. Erickson. Petitioner was referred to Dr. Erickson by Dr. Engel. PX 6. Dr. Engel testified that he believed the surgery of September 9, 2011, was reasonable and necessary to treat Petitioner's complaints of radicular pain. PX 6, p. 18. Dr. Engel opined that the disc disease was represented by MRI and the radiculopathy was demonstrated on the EMG. P. 18. Dr. Engel further opined that Petitioner's subjective complaints of pain and radiculopathy improved after the surgery. P. 19.

Petitioner was returned to see Dr. Erickson as his pain increased by November 2011, despite post-op physical therapy. Following an MRI dated January 16, 2012 which indicated a protrusion at L5-S1, the radiologist indicated severe compression of the descending left S1 nerve root with neural foraminal stenosis indicating L5 nerve root irritation as well. P. 22. Dr. Engel testified that he believed the radiculopathy returned due to scar formation irritating the nerve roots. P. 22. Contrary to the opinion of Dr. Singh, Dr. Engel opined that Petitioner's subjective complaints of left sided symptoms down to his left foot "matched" the MRI and EMG results which he opined indicated an S1 problem/distribution. P. 24. Dr. Erickson performed another foraminotomy at L5-S1 and dissected scar tissue as well as another discectomy at that same level. P. 26. Thereafter, Petitioner underwent an SI injection due to post-operative sacroiliitis. P. 28. Petitioner also underwent an epidural lysis of the scar tissue performed by Dr. Engel on August 14, 2012 and March 14, 2013. P. 28-33. Thereafter, Petitioner attended work conditioning and was released by Dr .Erickson on June 19, 2013 with permanent restrictions.

On cross-exam, Dr. Engel testified that he was aware that surgery of any type was not prescribed or recommended by Drs. Sclamberg, Sokolowski, Ross, Kranzler, or Ramirez. Dr. Erickson is the only doctor who prescribed any type of surgery for Petitioner. However, Dr. Engel again opined that after Petitioner underwent the foraminotomy and disecetomy surgeries, his pain complaints reduced from 9/10 to 2/10 indicating to Dr. Engel that the surgeries were reasonable and necessary. PX 6. P. 42-43.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law. The parties stipulated that Petitioner suffered an accident on May 12, 2008, which arose out of and in the course of the employment when he fell from a machine onto his back. ARB EX 1. Petitioner's initial care and treatment was accepted and was paid by Respondent and Petitioner received TTD for a total of 14 weeks through 10/20/08, the date of his

examination by Dr. Singh. ARB EX 1. On that date, Dr. Singh opined that Petitioner was at maximum medical improvement and required no further medical care.

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

Based upon a preponderance of the credible evidence, including petitioner's testimony, medical records and testimony, and the video surveillance, the Arbitrator finds that Petitioner's condition of ill-being in his low back was causally related to the undisputed work accident through October 20, 2008, the date of Dr. Singh's examination. Petitioner's condition of ill-being thereafter, was not causally related to the accident of May 12, 2008. In so finding, the Arbitrator relies on and assigns greater weight to the video surveillance of Petitioner in combination with the opinions of Dr. Singh. The Arbitrator finds that the video surveillance buttresses the opinions of Dr. Singh including his opinion that Petitioner exhibited Waddell signs and nonanatomical findings without objective support. The Arbitrator places greater support on the video evidence and the opinion of Dr. Singh over the records and opinions of Petitioner's numerous medical providers including chiropractic physicians, orthopedic surgeons, neurologists, and pain management physicians, all within the referral of Marque Medicos and associated medical facilities.

Dr. Singh indicated that Petitioner was at MMI and needed no further treatment as of October 20, 2008. Many of the physicians involved with Petitioner's care and treatment relied upon the EMG from July 11, 2008, which revealed acute denervation at the L4-5 level. Dr. Kern Singh reviewed the EMG and concluded that it was fraught with a high level of false positivity. Additionally, Dr. Singh relied upon the fact that the claimant had a discrepancy between his subjective and objective complaints. Based upon physical examination, Dr. Singh found no objective criteria to support the subjective complaints. Dr. Singh further opined and testified that the CT myelogram did not reveal spinal stenosis. Additionally, the CT myelogram revealed more right greater than left sided foraminal stenosis which did not correlate to the subjective complaints. Based on the foregoing, the Arbitrator finds causal connection for Petitioner's complaints through October 20, 2008. Thereafter, Petitioner's condition of ill-being is not causally related to the accident of May 12, 2008.

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

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related injuries through October 20, 2008, pursuant to Sections 8 and 8.2 of the Act. The Arbitrator finds that Respondent shall receive credit for amounts paid and/or pursuant to the parties' agreement reflected in RX 7. In addition to the opinion of Dr. Singh, the Arbitrator further references the testimony of the Utilization Review physicians. RX 4, 5 and 6. Testifying with respect to Utilization Reviews was Dr. Lawrence Humberstone, DC, who concluded that Petitioner's chiropractic care was excessive. Additionally, Dr. Todd Hagle, as well as Dr. Kenneth Smith also concluded that a majority of Petitioner's care and treatment and the charges associated therewith were unreasonable and unnecessary.

K. Were temporary benefits are in dispute?

Based upon the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that the 14 weeks of temporary total disability benefits that were extended commencing 7/15/08 through 10/20/08 was appropriate and that no additional worker's compensation benefits are due and owing subsequent to October 20, 2008. ARB EX 1.

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

Based upon the foregoing, the Arbitrator finds that on May 12, 2008, Petitioner sustained a severe low back strain with some arguable disc pathology. Dr. Singh testified that he would have recommended conservative treatment for Petitioner's complaints. He further opined that Petitioner was at MMI for his causally related condition and was not in need of any further treatment subsequent to October 20, 2008. Given Petitioner's demonstrated abilities on the video surveillance and on his trial testimony regarding his current work abilities, the Arbitrator finds that Petitioner sustained 10% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC034709
Case Name	CHEN, MATTHEW v. CITY OF CHICAGO DEPT OF AVIATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0392
Number of Pages of Decision	32
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	RICHARD JOHNSON
Respondent Attorney	PETER PUCHALSKI

DATE FILED: 8/3/2021

DISSENT

/s/ Christopher Harris, Commissioner

Signature

21IWCC0392

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

MATTHEW CHEN,

Petitioner,

vs. NO: 13 WC 34709

CITY OF CHICAGO,
DEPARTMENT OF AVIATION,

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 causal connection, medical benefits, temporary total disability (TTD), and permanent partial disability (PPD), 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.

Based upon the evidence, the Commission vacates the PPD award of 30% person-as-a-whole. As a result of Petitioner's January 2, 2013 work-related injury, Petitioner has lost access to his usual and customary line of employment and, therefore, the Commission finds Petitioner is entitled to a wage differential award under section 8(d)(1) of the Act.

Under the Act, when a claimant sustains a disability, an issue arises concerning what type of compensation he is entitled to receive, a wage differential award (8(d)(1)) or a percentage-of-the person-as-a-whole award (8(d)(2)). 820 ILCS 305/8(d) (West 2012); *Gallianetti v. Industrial Comm'n*, 315 Ill. App. 3d 721, 727, 734 N.E.2d 482, 487, 248 Ill. Dec. 554 (2000). Our supreme court has expressed a preference for wage differential awards. *Id.* (citing *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 438, 433 N.E.2d 671, 674, 60 Ill. Dec. 629 (1982)). The purpose of a wage differential award under section 8(d)(1) is to compensate an injured claimant for his reduced earning capacity. *Dawson v. Workers' Compensation Comm'n*, 382 Ill. App. 3d 581, 586,

888 N.E.2d 135, 139, 320 Ill. Dec. 918.

To qualify for a wage differential under section 8(d)(1) of the Act (820 ILCS 305/8(d)(1) (West 2012)), a claimant must prove (1) partial incapacity which prevents him from pursuing his 'usual and customary line of employment' and (2) an impairment of earnings." *Gallianetti v. Illinois Industrial Comm'n*, 315 Ill. App. 3d 721, 730, 734 N.E.2d 482, 248 Ill. Dec. 554 (2000). In order to prove an impairment of earnings, a claimant must prove his actual earnings for a substantial period before the accident and after he returns to work, or in the event that he has not returned to work, he must prove what he is able to earn in some suitable employment. *Id.*

Where the claimant is not working at the time of the hearing, it is important to note that section 8(d)(1) requires that an average wage be derived from suitable employment for the claimant. Suitable employment is employment in which the claimant is both able and qualified to perform. In order to calculate a wage differential award, the Commission must identify, based on the evidence in the record, an occupation that the claimant is able and qualified to perform, and apply the average wage for that occupation to the wage differential calculation. -*Crittenden v. Ill. Workers' Comp. Comm'n.*, 2017 IL App (1st) 160002WC.

If the claimant is not working at the time of the calculation, the Commission must rely on functional and vocational expert evidence. See *Gallianetti*, 315 Ill. App. 3d at 730 (labor market survey); *Levato*, 2014 IL App (1st) 130297WC at ¶12-¶13 (vocational rehabilitation specialist and labor market survey); *United Airlines, Inc.*, 2013 IL App (1st) 121136WC at ¶4-¶7 (vocational rehabilitation specialists).

Here, the Petitioner sustained a work-related injury on January 2, 2013 resulting in light duty work restrictions. Petitioner underwent a course of treatment to his low back followed by two valid Functional Capacity Examinations (FCE).

The first FCE was performed on March 18, 2013. While it was noted that considerable question should be drawn to the reliability and accuracy of Petitioner's reports of pain and disability, Petitioner did give a near full level of physical effort. The FCE reviewer further stated that he was not judging the intent of the Petitioner and that Petitioner's subjective reports should not be disregarded and should be considered within the context of the findings. Based upon the FCE, Petitioner was not capable of performing the physical demands of his pre-injury job. PX.1.

Respondent subsequently obtained a Section 12 examination on October 8, 2013 from Dr. Thomas Gleason of Illinois Bone & Joint. Based upon his review of the medical records, including the FCE, Dr. Gleason opined that the Petitioner suffered a permanent aggravation of a pre-existing condition. He further noted that the Petitioner was capable of working in the medium level prior to the injury, and now, he could only work in the light duty level. PX.8. Petitioner was at maximum medical improvement (MMI) and limited to light duty work. Dr. Gleason noted that the Petitioner sustained a permanent partial disability as a result of an aggravation of a pre-existing condition which occurred during his work-related accident on January 2, 2013. *Id.*

During Dr. Gleason's deposition, he testified that the Petitioner's right low back pain, in the absence of positive objective findings on physical examination of the low back, was related to the work-related accident. He described the condition as a manifestation and aggravation of a pre-existing degenerative condition. PX.8. pg.12. Dr. Gleason opined that Petitioner's permanent restrictions were not likely to change. PX.8. pg.13. Dr. Gleason further stated that he found no evidence that the Petitioner was malingering. PX.8. pg.34 & 36.

Petitioner underwent a second FCE on April 23, 2014. Per the FCE, Petitioner did not meet the job demands for lifting, carrying, pushing, pulling, balancing, stooping, crouching, or twisting. PX.5. While the Petitioner did not meet the heavy-duty requirements for his job as a machinist, he was capable of working in a sedentary capacity with no lifting, carrying, and pushing or pulling greater than 10-pounds. *Id*. Subsequently, Dr. David Fardon of Midwest Orthopedics at Rush reviewed the FCE on May 8, 2014 and noted there was no conclusion the FCE was invalid. *Id.* Because the sedentary restrictions precluded Petitioner from working in his pre-injury occupation, Dr. Fardon placed Petitioner at MMI with permanent work restrictions consistent with the FCE. *Id.* The Respondent did not accommodate the sedentary work restrictions.

The sole opinion questioning the permanent restrictions and the Petitioner's effort and ability to work came from Respondent's second Section 12 examiner, Dr. Alexander Ghanayem. Dr. Ghanayem was hired by the Respondent to perform an examination on March 19, 2018. He found that Petitioner's subjective complaints of back and right-sided leg pain were not substantially based on the results of the MRI and Petitioner displayed nothing more than symptom magnification and nonorganic pain behaviors. He found the findings on the 2013 MRI were degenerative in nature and not traumatically induced. While Petitioner sustained an aggravation, Dr. Ghanayem opined that the Petitioner's condition was resolved and that he exhibited signs of symptom magnification. The final diagnosis was symptom magnification. Dr. Ghanayem stated that the Petitioner could work full duty. RX.7 & RX.8.

It is the Commission's finding that the record does not support Dr. Ghanayem's opinion. The Petitioner underwent two valid FCEs and both FCEs were reviewed by two different physicians. Respondent's first Section 12 examiner, Dr. Gleason, reviewed the FCE and found no evidence of symptom magnification. He was also of the opinion that the Petitioner needed permanent restrictions as a result of the work accident. Those restrictions precluded the Petitioner from working his pre-injury occupation. Dr. Fardon reviewed the second FCE and noted it was not invalid. He also placed permanent restrictions on the Petitioner and noted that the Petitioner was precluded from working his pre-injury occupation. Based upon the credible opinions of Dr. Gleason and Dr. Fardon, coupled with the valid FCE results, the Commission finds that the Petitioner sustained an aggravation of his pre-existing condition that resulted in permanent restrictions. Because of those restrictions, the Petitioner is precluded from working his pre-injury occupation.

The record reflects that Petitioner had a history of psychological issues prior to his accident at work. Dr. Brandt's June 4, 2014 medical record revealed that Petitioner complained of considerable sadness, anxiousness, nervousness, and poor sleep for the past five to six years. PX.6. Subsequent to the being placed at MMI for his physical condition, the Petitioner began treating for these unrelated psychological issues. During his treatment for those psychological conditions, the

Petitioner also underwent vocational rehabilitation to address the physical effects of his work-related injury. While his psychological condition may have been part of his ongoing disability, that psychological disability had no bearing on the Petitioner's permanent work restrictions as a result of his post-accident physical condition. Petitioner's pre-accident psychological condition evolved after Petitioner's post-accident treatment for his physical injury, but the unrelated post-accident psychological condition and treatment cannot be disregarded when evaluating Petitioner's post-accident condition overall.

Vocational rehabilitation was subsequently initiated as Respondent was unwilling to accommodate the permanent restrictions. Nancy Knapp of Helmsmann Management Services was retained by the Respondent. Ms. Knapp worked with the Petitioner from October 2014 through July 2015. PX.13. During this period, the Petitioner applied for over 250 positions. Despite his effort, no job offers were extended to the Petitioner. Ms. Knapp's progress reports during this period demonstrate that the Petitioner was complying with the requirements of vocational rehabilitation. A labor market survey was completed by Ms. Knapp on March 27, 2015. PX.14. The labor market survey identified 14 potential employers having positions within Petitioner's 10-pound lifting restrictions. The positions Petitioner was capable of performing included a reservationist, a customer service representative, a dispatcher, a service writer, a health unit coordinator, a file clerk, and a front desk agent. *Id.* Petitioner could expect to earn $11.78 per hour. *Id.*

Despite Petitioner's effort with Ms. Knapp, Respondent terminated Ms. Knapp and retained Lisa Helma of Vocamotive. Ms. Helma began vocational rehabilitation on August 11, 2015. PX.13. Ms. Helma opined that Petitioner lost access to his usual and customary occupation as a machinist. Petitioner remained employable and should be able to locate employment in any position congruent with his level of education, work experience, and physical capabilities. Positions available to the Petitioner included a medical records clerk, a health information technician, an administrative assistant, a service writer, and a front desk clerk. Ms. Helma opined that the Petitioner could expect to earn between $10.00 to $15.00 per hour. Respondent terminated vocational rehabilitation on September 9, 2015 based upon Ms. Helma's opinion that Petitioner was taking excessive breaks during vocational rehabilitation. *Id.*

Petitioner's counsel obtained a vocational rehabilitation evaluation from Susan Entenberg of Rehabilitation Services Associates on September 14, 2017. PX.15. Ms. Entenberg opined that Petitioner was not capable of performing his past work as a machinist and would be an appropriate candidate for vocational rehabilitation for direct job placement. It was Ms. Entenberg's opinion that Petitioner sustained a reduction in earning power and a loss of job security. She further opined that Petitioner performed a diligent job search with Liberty Mutual from October 2014 through July 2015. As Petitioner had no transferable skills, he could expect to earn between $10.00 to $15.00 per hour. *Id*.

Petitioner testified that he is still a member of the union and an employee of the City of Chicago. His current hourly rate of pay is $48.93. T.31-32.

Based upon the above, the Commission finds that the Petitioner established both a partial incapacity that prevents him from pursuing his usual and customary line of occupation and an

impairment of earnings. The Commission finds that Petitioner is capable of earning $15.00 per hour in suitable occupations as identified by Ms. Entenberg. Petitioner's unrebutted testimony was that his current hourly rate of pay is $48.93. Therefore, the Petitioner is entitled to a wage differential award of $904.80 per week, commencing September 10, 2015. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on September 21, 2020, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,154.61 per week for a period of 70-1/7 weeks, (January 3, 2013 through May 8, 2014) that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $1,154.61 per week for a period of 69-6/7 weeks, (May 9, 2015 through September 9, 2015), as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $904.80 per week commencing September 10, 2015, as provided in § 8(d)1 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.

Under Section 19(f)(2) of the Act, no "county, city, town township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 3, 2021

Marc Parker
Marc Parker

CAH/tdm
O: 7/15/21
052

Barbara N. Flores
Barbara N. Flores

DISSENT

I respectfully dissent from the majority as I believe a wage differential award is not proper

in this case.

Petitioner sustained a very small disc protrusion as the result of the accident. In support of this finding, I find the opinions of Dr. Ghanayem and Dr. Gleason persuasive. Dr. Ghanayem's Section 12 examination found no neurological deficits and revealed that the Petitioner had full motor strength, no sensory loss, and a negative straight leg raise for radicular pain. Dr. Ghanayem found positive Waddell signs, and opined that Petitioner's subjective complaints did not correlate with any his physical examination findings or the MRI results. Dr. Ghanayem opined that Petitioner could return to his pre-injury occupation.

Dr. Gleason's findings were similar to those of Dr. Ghanayem. Dr. Gleason found no positive objective findings during his examination, and with no correlation to Petitioner's subjective complaints of right lower extremity weakness. Dr. Gleason's review of the MRI also revealed no evidence of neurological compression and the MRI did not correlate with Petitioner's complaints. Dr. Gleason diagnosed Petitioner with right lower back pain in the absence of any positive objective findings. It was Dr. Gleason's opinion that Petitioner could, at a minimum, work at the light duty level, and that he could perform his pre-injury occupation at the maximum. I find the evidence supports that Petitioner could return to work full duty and without restrictions.

I believe the FCE results should have been given little, if any, weight with regard to the resulting restrictions. The FCE contained a caveat indicating that considerable question should be drawn as to the reliability and accuracy of Petitioner's reported pain and disability. This statement, when read in conjunction with Dr. Ghanayem and Dr. Gleason's examination findings, establishes that permanent restrictions are not necessary and nullifies the need for vocational rehabilitation.

After the MMI date of May 8, 2014, Petitioner began treatment for physical and mental ailments unrelated to the work accident. In *PAR Elec. V. Ill. Workers' Comp. Comm'n*, 2018 IL App (3d) 170656WC, the court addressed the issue of causal connection and an intervening accident. The court held that "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.

Like the Arbitrator, I believe the record does not establish that the psychological issues, which began to manifest well after being placed at MMI, are related to the work accident. The evidence is clear that these psychological conditions were triggered by conditions unrelated to the work accident.

Petitioner subsequently underwent vocational rehabilitation due to his permanent restrictions. While the Petitioner gave a good faith effort during his vocational rehabilitation – in particular searching for various positions - such effort was unnecessary as Petitioner was capable of returning to his pre-injury occupation without restrictions. Petitioner's inability to work was related to his psychological conditions, not his work accident.

The Petitioner suffered a very small disc protrusion at the L5-S1 level as a result of his

accident and he reached maximum medical improvement on May 8, 2014. The record supports the Arbitrator's finding that "Petitioner did not engage in any meaningful lower back treatment from May 8, 2014 through the date of hearing." Respondent's liability for this incident was resolved as of May 8, 2014. Any ongoing treatment after May 8, 2014 was the result of his unrelated psychological condition.

However, I believe that the record supports reducing the PPD award to 12.5% MAW down from 30% MAW. I would assign the following weight to each subsection of Section 8.1(b) of the Act:

(i) I would assign greater weight to subsection (i) as Dr. Gleason performed an impairment rating finding Petitioner sustained 1% PPI.

(ii) I would assign some weight to subsection (ii). The Petitioner was employed as a Machinist. He sustained a very small disc protrusion. Both Dr. Ghanayem and Dr. Gleason were of the opinion that Petitioner was capable of returning to work and that his subjective complaints did not correlate with any physical examination findings or the MRI. Because of this, Petitioner's injuries would not have a substantial effect on his occupation.

(iii) I would assign some weight to subsection (iii). Petitioner was 37-years old at the time of his injury. Because of his age, he has a longer work life expectancy in which to experience the effects of the injury.

(iv) I would assign no weight to subsection (iv) as there is no evidence of a diminished earning capacity. While vocational rehabilitation was undertaken in this case, it was not necessary as Petitioner was capable of returning to work full duty.

(v) I would assign significant weight to subsection (v). As stated above, the Petitioner sustained a very small disc protrusion at L5-SI. He underwent conservative treatment with some injections. He was placed at MMI as of May 8, 2014. Dr. Ghanayem and Dr. Gleason both found that the objective evidence did not support Petitioner's subjective complaints. I believe the evidence supports that Petitioner's ongoing issues are related to his psychological conditions, which are not related to the work accident.

Based upon the above, I would find that Petitioner failed to establish an entitlement to a wage differential award and, instead, award Petitioner 12.5% person-as-a-whole.

Christopher A. Harris
Christopher A. Harris

CHEN, MATTHEW Case# **13WC034709**
Employee/Petitioner

CITY OF CHICAGO DEPT OF AVIATION
Employer/Respondent

On 9/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0766 HENNESSY & ROACH PC
PETER PUCHALSKI
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

M. Chen v. City of Chicago, etc., 13 WC 034709

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

Matthew Chen
Employee/Petitioner

Case # **13 WC 034709**

v.

City of Chicago Department of Aviation
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 **October 17, 2019 and November 5, 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; Is Petitioner entitled to benefits under Section 8(d)(1) or Section 8(f)

M. Chen v. City of Chicago, etc., 13 WC 034709

FINDINGS

On **January 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$90,059.84**; the average weekly wage was **$1,731.92**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$104,069.51** for TTD, **$0.00** for TPD, **$56,575.89** for maintenance, and **$0.00** for other benefits, for a total credit of **$162,799.82**.

Respondent is entitled to a credit under Section 8(j) of the Act, per the agreement of the Parties.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 150 weeks, because the injuries sustained caused permanent partial disability of 30% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 1/2/2013 through 11/5/2019 in a lump sum, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

September 18, 2020

Date

SEP 2 1 2020

FINDINGS OF FACT

TESTIMONY OF PETITIONER MATTHEW CHEN

Petitioner testified via a Cantonese Chinese/English interpreter.

On January 2, 2013, Petitioner was 37 years old and worked as a machinist for The City of Chicago. (TR P 12).

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 2, 2013. Petitioner testified that he was repairing a garbage truck when he fell onto his back. (TR P 13).

Petitioner was taken by ambulance to Mount Sinai Hospital and treated in the emergency room. (TR P 13-14).

Petitioner testified that he completed a course of treatment with a company clinic, U.S. Healthworks. (TR P 14). Petitioner had a lumbar spine MRI on January 23, 2013. (TR P 15).

Petitioner then pursued chiropractic treatment with Dr. Kauf and underwent a steroid injection with Dr. Paul Marsiglia. (TR P 16). Petitioner testified that it was his decision to seek chiropractic treatment. (TR P 42). Petitioner testified that his treatment with Dr. Kauf and Dr. Marsiglia lasted through June 2013. (TR P 42).

Petitioner testified that he completed an FCE on March 18, 2013. (TR P 16).

Petitioner next treated with an orthopaedic surgeon, Dr. David Fardon. Treatment with Dr. Fardon/Midwest Orthopaedics began in July 2013. (TR P 42). At the direction of Dr. Fardon, Petitioner performed physical therapy and work conditioning. (TR P 17). An epidural steroid injection was completed on December 23, 2013. (TR P 18). Petitioner testified that he experienced no pain relief following the injection and had an adverse reaction including fevers and chills. (TR P 44).

Petitioner testified that he completed a second FCE on April 23, 2014. (TR P 18). Petitioner treated with Dr. Fardon through May of 2014, when he was released to return to light duty work. Petitioner testified that his restrictions were not accommodated by Respondent. (TR P 18).

Petitioner testified that he regularly treated for symptoms of low back pain from January 2013 through May 2014, a period of one year and four months. (TR P 46). During this timeframe Petitioner never underwent any surgical procedure. (TR P 46). Petitioner stopped treating regularly for lower back pain in May 2014. (TR P 46).

Petitioner testified that he never treated with a psychologist, psychiatrist or counselor between January 2013 and May 2014 (TR P 47). Petitioner was never hospitalized for a mental health condition. From January 2013 through May 2014, Petitioner was never prescribed or used anti-depressant medication. (TR P 48).

Petitioner identified Dr. Brandt as his primary care physician. (TR P 16, 48). Petitioner testified about the various conditions that he suffered from and treated for between June and August 2014. Petitioner had issues with

belching, burping and swallowing and treated with a GI specialist and dietician. (TR P 49). Petitioner was seen by a dermatologist for facial itching (TR P 49). Petitioner saw a urologist for urinary frequency problems. (TR P 49). In August 2014, Petitioner treated with a liver specialist Dr. Rinella. Petitioner testified that he was diagnosed with a fatty liver and that he was very scared when he first received this news. (TR P 49). Petitioner testified that he thought he was suffering from liver failure in August 2014. (TR P 49-50). Petitioner admitted that in August 2014 he was researching his symptoms on a daily basis. (TR P. 50).

Petitioner had a CT Scan of the chest completed in September 2014. Petitioner testified that the results were abnormal and that he believed he was going to die from lung cancer. (TR P 52). Petitioner admitted that no physician ever diagnosed cancer. (TR P 56).

Between August and September 2014 Petitioner had three separate visits to the emergency room at Northwestern Memorial Hospital. During an emergency room visit on September 24, 2014 Petitioner was evaluated by a psychiatrist. (TR P 56).

Petitioner testified that he was referred by Dr. Brandt to a psychiatrist, Dr. Lee Schwartz, in September of 2014. (TR P 19, 57). Petitioner saw Dr. Schwartz on two occasions. At the first visit, Petitioner testified that Dr. Schwarz prescribed medications. (TR P 57). Petitioner admitted that he did not use the medications prescribed by Dr. Schwartz. (TR P 57). Petitioner testified that he made a personal decision to stop seeing Dr. Schwartz but was never discharged from care. (TR P 58).

Petitioner testified that he started working with a vocational counselor, Ms. Nancy Knapp on October 1, 2014. (TR P 20). Petitioner would meet with Ms. Knapp every 1-2 weeks. (TR P 21). Petitioner prepared a resume and started job searching. (TR P 21). Petitioner worked with Ms. Knapp through August 2015. During this time period, he applied for 251 jobs. (TR P 21). Petitioner did not complete any sort of training. (TR2 P 7). Petitioner testified that he communicated with Ms. Knapp in English. (TR2 P 7).

Petitioner testified that in August 2015 he started a vocational program with Vocamotive. (TR P 21). The program was different and Petitioner was provided computer training. (TR P 22). Petitioner testified that he took frequent breaks due to significant pain complaints, lack of concentration and thoughts of suicide. (TR P 23). Petitioner testified that he received a written warning addressing his excessive breaks. (TR2 P 9). Petitioner was terminated from the Vocamotive program in September 2015. (TR2 P 12). Petitioner testified that when he was discharged from the Vocamotive program his weekly benefits were terminated. (TR P 23).

In September 2015, Petitioner was seen by Dr. Scott Glaser for low back pain complaints. Petitioner testified that his attorney told him to see Dr. Glaser. (TR P 58). Petitioner testified that an epidural steroid injection was recommended but never approved. (TR P 24).

Petitioner testified that he completed testing with Dr. Jean Tzou in June 2016. Dr. Tzou recommended that Petitioner see a psychiatrist. (TR P 24).

Petitioner began treating with a psychiatrist, Dr. Hong Cao on October 4, 2016. Petitioner was placed on medication. (TR P 25). Petitioner testified to seeing a therapist, Dr. Moore. (TR P 25).

At the request of his attorney, Petitioner was evaluated by a vocational counselor, Susan Entenberg, on September 8, 2017. (TR P 26). The interview with Ms. Entenberg was completed in English. (TR2 P 14). This evaluation took place approximately two years after Petitioner's discharge from the Vocamotive program in

September 2015. (TR2 P 14). Petitioner admitted that he did not search for employment from September 2015 through September 2017. (TR2 P 14). Petitioner testified that he saw Ms. Entenberg on one occasion and that Ms. Entenberg never provided job leads or any form of job training. (TR2 P 14-15).

From September 2017 through the date of hearing, Petitioner did not engage in any job searching activities or job training. (TR2 P 15-16).

In November 2017 Petitioner was taken to Thorek Hospital after expressing suicidal ideations to Dr. Cao. (TR P 26-27). Petitioner testified that in November 2017 he had a very stressful domestic situation with his wife who was filing for divorce. (TR P 60). Petitioner testified that his wife filing for divorce made him feel like killing himself. (TR P 60).

On December 30, 2017, Petitioner testified that he was involuntarily admitted to MacNeal Hospital after again threatening to commit suicide. (TR P 27). Petitioner was discharged from MacNeal on January 5, 2018. (TR P 27). During this inpatient hospital stay Petitioner was dealing with the same domestic and marital issues. (TR P 61).

In March of 2018 Petitioner testified that he began treating with Dr. Michael Swain. (TR P 28). Petitioner selected Dr. Swain on his own and was not referred by any physician. (TR P 62). Petitioner has treated with Dr. Swain through the date of hearing. Dr. Swain prescribed Alprazolam and Amitriptyline. (TR P 29).

Petitioner testified that he has not returned to work since January 2, 2013. (TR P 29).

Petitioner testified that he is member of Local 126. Petitioner testified that his currently hourly wage would be $48.93. (TR P 32). Petitioner testified that he has an Associate's Degree in general studies and a Bachelor's Degree in Health Information Services. Petitioner admitted that his college courses were taught in English and that he participated in those courses without the assistance of an interpreter. (TR2, P 4). Petitioner testified to prior employment positions as a driver and mechanic and prior internships that involved medical coding and medical records. (TR2 P 5).

Petitioner testified that his pain complaints prevent him from completing household chores, recreational activities and positional tasks. (TR P 32 – 35). Petitioner testified that he suffers from depression on a daily basis. (TR P 36). Petitioner claimed that his ability to read the English language was diminished as a result of the work accident of January 2, 2013. (TR2 P 10). Petitioner testified that his reading abilities diminished within weeks of the January 2013 injury. (TR2 P 10). Petitioner testified that he currently suffers from symptoms involving the low back, bilateral legs, right foot, neck, bilateral arms, right shoulder and right hand and fingers. (TR2 P 19-21).

Petitioner testified that he uses a cane to walk. (TR2 P 18). Petitioner started using a cane in 2015. No physician ever prescribed a cane or recommended that Petitioner use a cane. (TR2 P 19). Petitioner admitted that he never used a cane during his initial course of treatment from January 2013 through May 2014. (TR2 P 19).

Petitioner testified that he has not seen any physician who specializes in spinal injuries for the last three years. (TR2 P 23). Petitioner never returned to his original orthopedic surgeon, Dr. Fardon, after May 2014. (TR2 P 23).

MEDICAL EVIDENCE

Petitioner was seen at US Healthworks on January 3, 2012. (PX 1, P 3). Petitioner presented with lower back and head injuries attributed to a fall he suffered while fixing a leak in a hopper of a garbage truck. (PX 1, P 3). Petitioner was diagnosed with a lower back strain, blunt head trauma and lumbago. (PX 1, P 3). Petitioner was placed under a seated work only restriction and the attending physician did not anticipate any permanent disability from the injury. (PX 1, P 3).

Petitioner returned on January 7, 2013 and reported that his low back pain was radiating down the right lower extremity into the foot. (PX 1, P 24). Petitioner was instructed to begin physical therapy and was prescribed a Medrol dose pack. (PX 1, P 25-27). Petitioner began performing physical therapy through US Healthworks.

The next office visit was January 15, 2013. Petitioner was instructed to complete his physical therapy and there was discuss of ordering an MRI if symptoms persisted. (PX 1, P 37). The MRI was ordered at the next visit on January 22, 2013. (PX 1, P 49).

On January 23, 2013 a lumbar spine MRI was completed at Athletic Imaging. At L5-S1 there was "a very small broad based central to right sided disc protrusion." (PX 1, P 53). There was no significant stenosis and the S1 nerve root was no effaced. (PX 1, P 53).

Petitioner was seen at US Healthworks on January 25, 2013. The MRI was reviewed and Petitioner was diagnosed with a lumbar strain. (PX 1, P 54). Additional physical therapy was ordered. (PX 1, P 55). On February 8, 2013 Petitioner reported some improvement in his symptoms and there was a referral for a pain management evaluation. (TR P 62, 69).

On March 1, 2013 Petitioner told the physicians at US Healthworks that he was completing chiropractic treatment. (PX 1, P 85). The office note confirms that chiropractic care was "per pt's choice" and the attending physician cautioned that "chiropractic care will most likely not resolve his sx's." (PX 1, P 85). Petitioner requested a handicapped parking pass and the request was denied, "discussed that he is not handicapped + would not qualify for sticker." (PX1, P 85). Petitioner was released to return to work with a 15 pound restriction. (PX 1, P 86).

An FCE was ordered when Petitioner was seen on March 8, 2013. (PX 1, P 92). There was a letter summarizing this office visit that referenced a recommendation for sacroiliac joint injections. (PX 1, P 95). Petitioner's MRI study was found to be "unremarkable." (PX 1, P 95).

An FCE was completed through US Healthworks on March 18, 2013. Petitioner met or exceeded all of the positional tasks required for his position as a machinist; Petitioner failed to demonstrate the ability to lift and carrying a medium physical demand level. (PX 1, P 100 – 101). Petitioner did demonstrate the ability to lift and carry at least 30 pounds. (PX 1, P 101). Petitioner was found to have given near full levels of physical effort. (PX 1, P 103). However, the report indicates that "considerable question should be drawn to the reliability and accuracy of Mr. Chen's reports of pain and disability." (PX 1, P 103).

Petitioner returned to US Healthworks on March 22, 2013 and additional physical therapy was ordered. (PX 1, P 105).

The final office visit with US Healthworks took place on April 17, 2013. Petitioner reported that his was completing chiropractic care and treating with a pain management physician Dr. Marsiglia. (PX 1, P 121). Petitioner was instructed to return on May 13, 2013 and Dr. Stewart did "anticipate discharging him at that time back to regular work." (PX 1, P 121). Petitioner never returned to US Healthworks.

Petitioner sought chiropractic treatment on his own with Dr. Michael Kauf of the Chicagoland Clinic. An initial evaluation was completed by Dr. Kauf on February 26, 2013. (PX 2). Dr. Kauf started treating Petitioner with manual traction and electric stimulation. (PX 2). An Evaluation Summary dated March 5, 2013 indicates that Petitioner completed a modified Oswestry that self-quantified his level of disability at "crippled." (PX 2). The medical record exhibit demonstrates that Petitioner completed 23 chiropractic visits that lasted through May 2, 2013. (PX 2).

Dr. Paul Marsiglia was identified as Petiitoner's pain management physician. Dr. Marsiglia completed an initial evaluation on March 11, 2013. (PX 3). Dr. Marsiglia diagnosed an L5-S1 disc protrusion and lumbar radiculopathy. Dr. Marsiglia recommended physical therapy and a right L5-S1 epidural steroid injection. (PX 3).

Petitioner returned on April 8, 2013 and on physical examination Dr. Marsiglia found a negative straight leg raise test bilaterally, full and symmetrical strength in the bilateral upper and lower extremities and no evidence of sensory loss. (PX 3). Dr. Marsiglia opined that Petitioner's disc protrusion was "small" and that Petitioner "should not have any permanent disability." (PX 3).

Dr. Marsiglia examined Petitioner on April 23, 2013 and Petitioner's pain was rated as a 2/10. (PX 3). Petitioner was instructed to perform work conditioning. (PX 3).

The final office visit with Dr. Marsiglia took place on June 3, 2013. Dr. Marsiglia again recommended work conditioning and was anticipating a full duty work release following a work conditioning program. (PX 3). Petitioner did not return for additional treatment with Dr. Marsiglia.

Petitioner completed a work conditioning program through ATI Physical Therapy from June 3, 2013 through August 4, 2013. (PX 4). Curiously, the program was initiated at a sedentary level, well shy of the functional abilities Petitioner demonstrated at his March 2013 FCE. (PX 4). Petitioner was discharged from the program on August 5, 2013. The final progress report found that Petitioner was functioning at a light physical demand level. The therapist noted that Petitioner was "apprehensive throughout the entire program about making progressions to his weights." (PX 4).

Dr. David Fardon of Midwest Orthopaedics was identified as Petitioner's treating orthopaedic surgeon. Dr. Fardon completed an initial evaluation on July 9, 2013. Petitioner completed an Patient Questionnaire and indicated that he was not referred by anyone to Midwest Orthopaedics. (PX 5). Dr. Fardon reviewed Petitioner's diagnostic studies and found the following, "I think these are all marginal findings and may be within normal range." (PX 5). Work conditioning was recommended and Petitioner was released to return to sedentary work. (PX 5).

Dr. Fardon examined Petitioner on July 30, 2013 and recommended an epidural steroid injection. (PX 5).

Petitioner was examined by Dr. Gunnar Andersson of the same orthopaedic group, on September 24, 2013. Dr. Andersson concurred with the recommendation for an epidural steroid injection. (PX 5). Dr. Andersson

anticipated that following a successful injection and work conditioning, Petitioner would return to his regular employment position without restrictions. (PX 5).

Dr. Thomas Gleason completed an independent medical examination on October 8, 2013. Dr. Gleason diagnosed Petitioner with right low back pain in the absence of positive objective findings on physical examination and unrelated right foot plantar fasciitis. (PX 8, X3). Dr. Gleason opined that Petitioner was capable of full time work in "at least" a light level per the discharge summary from an ATI work conditioning program. (PX 8, X3). Petitioner was assigned a 1% impairment rating pursuant to the sixth edition of the AMA guidelines. (PX 8, X3).

Petitioner was seen by Dr. Cheng, also of Midwest Orthopaedics, on December 23, 2013. Dr. Cheng administered a right L5 transforaminal epidural steroid injection. (PX 5).

Dr. Fardon examined Petitioner on January 21, 2014. Petitioner was found to have had an "idiosyncratic reaction" to the epidural steroid injection. (PX 5). Dr. Fardon recommended a repeat MRI. (PX 5).

A repeat MRI was completed at MRI of River North on February 6, 2014. The study demonstrated a broad-based disc protrusion at L5-S1 with "no direct nerve root impingement." (PX 5).

Petitioner returned for evaluation with Dr. Fardon on March 18, 2014. Dr. Fardon found that Petitioner's pains, "are not accompanied by any specific radicular pattern." (PX 5). Dr. Fardon recommended physical therapy with a transition to work conditioning. (PX 5).

An FCE was completed at Flexeon Rehabilitation on April 23, 2014. Petitioner was found to have given variable levels of physical effort. (PX 5). All of the Petitioner's weighted tolerances were less than the prior FCE results. (PX 5, PX 1 P 100-101). Petitioner's Heart Rate Analysis demonstrated virtually no difference between standing/resting heartrate and maximum heartrate. (PX 5). Petitioner's Oswestry questionnaire rated his level of disability at "crippled." (PX 5). Petitioner's PACT Spinal Function Sort resulted in an "unreliable profile." (PX 5). When Petitioner completed his carrying tests, he was only able to carry the weight of the box and then requested to lie down on the floor; Petitioner's heartrate during the activity started at 85 bpm and never raised over 87 bpm. (PX 5).

Petitioner's final office visit with Dr. Fardon took place on May 8, 2014. Dr. Fardon reviewed Petitioner's FCE report and noted the presence of "caveats and exceptions" based on Petitioner's less than optimal effort. (PX 5). Dr. Fardon also noted that the FCE was not invalid. Dr. Fardon opined that Petitioner was capable of sedentary work and could perform some midrange activities at the light-to-medium level. (PX 5). Petitioner was placed at maximum medical improvement. (PX 5).

Dr. Fardon completed a "Medical Examiner's Certificate For Disability Benefits" on the final service date of May 8, 2014. This document outlines Dr. Fardon's final work capacity opinion. Dr. Fardon opined that Petitioner was "unable to lift or carry more than 35 pounds." (PX 5).

Dr. David Brandt was identified as Petitioner's primary care physician. Dr. Brandt examined Petitioner on May 14, 2014. Petitioner requested a handicapped placard and alleged that he could not walk more than 50 feet at a time. (PX 6, P 14). Petitioner's FCE of April 23, 2014 found that Petitioner demonstrated the ability to walk for 11 minutes and 16 seconds. (PX 5). Dr. Brandt prescribed Lyrica for nerve pain. (PX 6, P 15).

Dr. Brandt next examined Petitioner on June 4, 2014. Petitioner presented for a general physical examination. Petitioner reported that he had considerable sadness, nervousness and poor sleep for 5–6 years. (PX 6, P 16).

Petitioner was seen on June 23, 2014 and Dr. Brandt found that Petitioner was ambulating with no limp. (PX 5, P 23).

Petitioner presented for evaluation in the emergency room at Northwestern Memorial Hospital on August 5, 2014. The primary complaints involved gastrointestinal issues/complaints. (PX 6, P 162). Petitioner did report anxiety as he was worried about cancer. (PX 6, P 162). On physical examination Petitioner was nontender at the back with no focal neurological deficits. (PX 6, P 163-163). On discharge, Petitioner was instructed to follow up with his primary care physician and GI specialist. (PX 6, P 164). An addendum record noted the following, "There appears to be an anxiety component to his symptoms but he denies depression, other psych symptoms. May benefit from outpt eval." (PX 6, P 165).

Petitioner was first diagnosed with a mental health condition on August 29, 2014. Dr. Brandt itemized a myriad of complaints that Petitioner was alleging including facial itching, bloating, belching, difficultly swallowing, increased urinary frequency, hepatic steatosis, episodic sadness and sleep difficulty. (RX 4; PX 6, P 58). Dr. Brandt noted that Petitioner was "googling his symptoms daily, is thinking of new medical testing to undergo, daily." (RX4; PX 6, P 58). Petitioner requested diabetes screening and a liver fibroscan. (RX 4; PX 6, P 58). Dr. Brandt diagnosed generalized anxiety disorder and noted that Petitioner's anxiety has increased over the summer. (RX 4; PX 6, P 60). Dr. Brandt found that Petitioner was "transfixed" upon having liver failure, diabetes and multiple other illnesses. (RX 4; PX 6, P 60). Dr. Brandt also diagnosed somatization disorder and noted that Petitioner had treated with a dermatologist, urologist, hepatologist, GI Specialist and was seen in the emergency room "all in the past month!" (RX 4; PX 6, P 60). Petitioner was referred to a psychiatrist, Dr. Lee Schwartz. (RX 4; PX 6, P 60).

Petitioner returned to the emergency room at Northwestern Memorial Hospital on September 8, 2014. The primary complaint was shortness of breath. (PX 6, P 166). Petitioner's mental health was ostensibly addressed, "PT reports he has been referred to a psychiatrist by his PMD but does not think he requires one; reports he is very concerned over potential health problems ever since he was diagnosed with fatty liver. A degree of anxiety is likely contributing to pt's presentation." (PX 6, P 167 – 168).

On September 10, 2014 Dr. Brandt found that Petitioner was transfixed upon his belching and epigastric pain/soreness and that he was "resigned to dying." (PX 6, P 61). On examination, Petitioner walked with a normal gait. (PX 6, P 62). Dr. Brandt chided Petitioner for not completing a psychiatric evaluation, "I told him that his resistance to my advice (which has been a recurrent theme) is hampering my ability to care for him." (PX 6, P 63).

Dr. Brandt saw Petitioner on September 17, 2014 and reviewed abnormal findings from a CT Scan. Petitioner was "highly anxious about his hepatic steatosis, feels he will now die from lung cancer." (PX 6, P 63). Dr. Brandt found that Petitioner "perseverates on death due to cancer." (PX 6, P 65).

On September 29, 2014 Petitioner returned for a third emergency room visit at Northwestern Memorial Hospital over a span of less than two months. Petitioner reported physical complaints to the back and right shoulder with headaches, bilateral hand numbness and abdominal discomfort. (PX 6, P 170). Petitioner stated,

"I don't know if the cancer spread from my stomach to my head." (PX 6, P 170). The attending physician, Dr. Malik, found evidence of major anxiety component and recommended a psychiatric assessment.

A psychiatric assessment was completed by Dr. Pedro Dago on September 29, 2014. Dr. Dago found that Petitioner was "somatically preoccupied since dx of fatty liver." (PX 6,P 70). Dr. Dago reached the following biopsychosical assessment, "PT has significant worry and fear of death in regard to lung nodules which he presumes is lung cancer. He associates other somatic experiences with a possible metastatis such as finger numbness or mild chest pain. His preoccupation with the symptoms has seemingly intensified over the past 1-2 months with several ED visits and multiple workups for complaints. (PX 6, P 75). Dr. Dago recommended follow-up treatment with Petitioner's primary care physician and a psychiatrist. (PX 6, P 75).

Petitioner was seen by a pulmonary specialist, Dr. Randy Orr, on September 19, 2014. Petitioner was found to be "highly anxious" about his pulmonary nodules and "frequently" requested that Dr. Orr "just cut out the nodules." (PX 6, P 65-66). Petitioner characterized his nodules as a "ticking time bomb" inside his chest. (PX 6, P 66). Dr. Orr noted that Petitioner was adamant about proceeding directly to surgery. (PX 6, P 67).

Dr. Lee Schwartz completed an initial psychiatric evaluation on September 30, 2014. The handwritten note reflects a diagnosis of generalized anxiety disorder; the section of Dr. Schwartz's office note addressing this diagnosis references Petitioner's pulmonary nodules and fatty liver. (PX 7, RX 1). Dr. Schwartz also diagnosed major depressive disorder, suspect panic attack and obsessive-compulsive disorder. (PX 7, RX 1).

Dr. Brandt examined Petitioner on October 8, 2014. Petitioner denied anxiety and said that he was not using the Clonazepam prescribed by Dr. Schwartz. (PX 6, P 77). Petitioner denied back pain. (PX 6, P 77)(emphasis added). On examination, Petitioner was not tender to percussion and palpation; Petitioner had a normal gait. (PX 6, P 78).

Petitioner had one return visit with Dr. Schwartz on October 10, 2014. Dr. Schwartz found that Petitioner was "clearly better" but was not using Clonazepam that was previously prescribed. (PX 7). The psychotherapy section of Dr. Brandt's report references a diagnosis of generalized anxiety disorder and somatization which was attributed to a diagnosis of hepatic steatosis, GERD and lung nodules. (PX 7). Petitioner never returned for additional treatment with Dr. Schwartz.

Petitioner was seen by Dr. Brandt on November 3, 2014 and reported low back pain but denied any radiation into the buttock or legs. (PX 6, P 79). On examination Petitioner again had a normal gait and no tenderness to percussion and palpation. (PX 6, P 81). Petitioner had "no pain" on examination. (PX 6, P 82). Petitioner requested a permanent handicapped parking placard but Dr. Brandt completed the form for six months. (PX 6, P 82).

Dr. Brandt examined Petitioner on March 18, 2015 for the purposes of seeking an updated Certificate for disability benefits. (PX 6, P 82). Dr. Brandt noted that Petitioner declined pain medication dispite significant subjective complaints. (PX 6,P 84). Dr. Brandt noted that Petitioner had a "reasonable gait." (PX 6, P 84).

Petitioner returned for evaluation with Dr. Brandt on June 30, 2015. Petitioner's mental health condition was addressed and Dr. Brandt noted that Petitioner "does not want counseling or medications for this. He does not want to see Dr. Schwartz (Psychiatry) for this again." (PX 6, P 85). Dr. Brandt completed a physical

examination and found full range of motion in the spine, no sensory or motor deficit and a negative, bilateral straight leg raise test. (PX 6, P 87).

Dr. Scott Glaser was identified as Petitioner's pain management physician. Dr. Glaser evaluated Petitioner on September 24, 2015. Dr. Glaser recommended a right transforaminal epidural steroid injection at L5-S1. (PX 9). Petitioner never returned for additional treatment with Dr. Glaser. Dr. Glaser's outstanding bill for $454.00 was offered into evidence as part of Petitioner's Exhibit #20.

Dr. Brandt completed a Medical Examiner's Certificate for Disability Benefits on Petitioner's behalf dated March 18, 2016. The Certificate indicates that Petitioner was to remain off work for 12 months. (PX 23).

Dr. Jean Tzou was identified as a treating psychiatrist. An initial consultation was completed on June 24,2016. Dr. Tzou diagnosed major depressive disorder and anxiety. (PX 25). The initial note indicates that Petitioner was fluent in English and had a "long list" of somatic complaints. (PX 25). Dr. Tzou also noted receipt of a lawyer's referral request and a packet of records provided by Petitioner's attorney. (PX 25). Records from Dr. Tzou document treatment/sessions through August 6, 2016.

On August 19, 2016 a repeat lumbar spine MRI was completed at Northwestern Memorial Hospital. By report, the study demonstrated "a mild disc bulge and annular fissure at L5-S1." (RX 15). There was no areas of abnormal cord signal and no mention of neurological compression. (RX 15).

Petitioner presented for an independent medical examination with Dr. Matthew Skarbek on October 28, 2016. Dr. Skarbek is a licensed clinical psychologist. (RX 2). Dr. Skarbek diagnosed Major Depressive Disorder, Somatic Symptom Disorder and Generalized Anxiety Disorder. (RX 2, P 8).

Dr. Skarbek opined that there was no compelling evidence that any psychological conditions found were directly caused or aggravated by Petitioner's work accident. (RX 2, P 8). Dr. Skarbek opined that Petitioner's mental health condition was made worse by Petitioner's reluctance and refusal to engage psychological services recommended by his physicians. (RX 2, P 8). Dr. Skarbek placed emphasis on the fact that Petitioner's psychological condition did not manifest until he was presented with information about other health conditions unrelated to his work accident. (RX 2, P 8). Dr. Skarbek found that it "must be considered a possibility" that Petitioner was exaggerating physical symptoms for secondary gain. (RX 2, P 10).

Dr. Hong Cao was identified as a treating psychiatrist. Dr. Cao completed an initial evaluation of Petitioner on October 4, 2016. (PX 10). Dr. Cao diagnosed major depressive disorder and anxiety disorder. (PX 10). Petitioner was placed on Remeron and therapy/counseling with a Chinese speaking provider was recommended. (PX 10).

Petitioner completed counseling with Victoria Te You Moore from October 5, 2016 through November 15, 2016. The counseling records were entered into evidence as Petitioner's Exhibit #22).

The records from Dr. Cao span from October 4, 2016 through December 29, 2017. On a whole the records reflect complaints of pain, but the review of symptoms reflects a benign musculoskeletal exam. (PX 10). The records also note ongoing marital and domestic issues. (PX 10). Dr. Cao's treatment was mainly prescription medication and Petitioner was prescribed Remeron and Cymbalta. (PX 10).

Dr. Cao's final office note was dated December 27, 2017. Dr. Cao had his staff call for an ambulance as Petitioner expressed suicidal intentions. (PX 10).

Petitioner was admitted on an in-patient basis at Thorek Memorial Hospital on November 25, 2017. The following history of injury was recorded, "Patient with known psychiatric history presenting with suicidal ideations, previous hx of suicide attempts. Has had multiple stressors recently. Wife filed for divorce, was sent over from local outpatient facility where he was receiving outpatient therapy. (PX 11). A note from December 2, 2017 recorded a complaint of back pain; imaging studies were ordered and refused by Petitioner. (PX 11). A physical examination was completed and Petitioner had no tenderness to palpation and full range of motion in the back. (PX 11). The records reflect a diagnosis of "major depressive disorder, recurrent, without psychotic features; rule out bipolar disorder." (PX 11).

Petitioner was treated in-patient from December 30, 2017 through January 5, 2018 at MacNeal Hospital. (PX 16). A Psychiatric Evaluation was completed on December 30, 2017 and the following history was recorded, "He reports that he was seeing a psychiatrist yesterday and he had informed this psychiatrist that he wanted to end his life. He reports he started having these thoughts after his wife has threatened to divorce him." (PX 16, P 131). The Discharge Summary reflects a diagnosis of Major Depressive Disorder and an instruction to use Olanzpaine and Remeron and to see his psychiatrist and therapist. (PX 16, P 8).

Psychotherapy records from the in-patient stay at MacNeal were admitted as Petitioner's Exhibit 17. Those records reflect complaints of chronic back pain and depression. (PX 17). Throughout the psychotherapy records Petitioner's gait was "without issues." (PX 17).

At the request of Petitioner's attorney, Dr. Robert Sharpe, a psychiatrist, completed a records review report dated March 5, 2018. In the report, Dr. Sharpe opined that Petitioner was suffering from major depressive disorder and that Petitioner's work injury was a contributory if not a major precipitating factor. (PX 18, X 1). Dr. Sharpe opined that Petitioner's psychological condition severely compromised his ability to function and prevented him from working. (PX 18, X 1). Dr. Sharpe opined that the psychological condition was permanent. (PX 18, X 1).

Petitioner began treating with a psychiatrist Dr. Robert Swain in March 2018. Petitioner's treatment records with Dr. Swain from March 2018 through March 2019 were entered into evidence as Petitioner's Exhibit 19. There are minimal handwritten notations for each service date. On a whole the records confirm complaints of back pain, more prominent over the last several months of treatment. (PX 19). The records also note ongoing marital and domestic issues. (PX 19). Finally, there are many references to Petitioner's workers' compensation claim, Petitioner's attorney and the Arbitrator/Arbitration. (PX 19).

Dr. Alexander Ghanayem examined Petitioner pursuant to Section 12 of the Act on March 19, 2018. Dr. Ghanayem is a board certified orthopedic surgeon and chairman of the Department of Orthopaedic Surgery & Rehabilitation at Loyola University. (RX 6). Dr. Ghanayem reviewed Petitioner's MRI study from January 23, 2013 and found a "small central disk bridge at L5-S1." (RX 7). Dr. Ghanayem found that Petitioner's subjective complaints of back and right-sided leg pain that are not based on his MRI and that Petitioner displayed "nothing more than symptom magnification and nonorganic pain behaviors on examination. (RX 7). Dr. Ghanayem placed Petitioner at maximum medical improvement and opined that Petitioner could work at least at the medium physical demand level. (RX 7). Dr. Ghanayem opined that there was no structural reason for Petitioner to walk with a limp and the MRI findings were not substantial enough to provide any measurable degree of disability. (RX 7).

Dr. Ghanayem completed an addendum report dated May 17, 2018. The report incorporated Dr. Ghanayem's review of repeat lumbar spine MRI films from August 19, 2016. (RX 8). Dr. Ghanayem opined that Petitioner could return to work on a full duty basis; the final diagnosis was symptom magnification. (RX 8).

Dr. Swain completed a Medical Examiner's Certificate of Disability Benefits dated December 31, 2018. The report indicates that Petitioner's depression is related to his ongoing severe physical pain. (PX 23). The Certificate indicates that Petitioner was to remain off work for the foreseeable future. (PX 23).

Dr. Swain's psychiatric records from March 2019 through September 2019 were entered into evidence as Petitioner's Exhibit #24. A note from August 12, 2019 includes a diagnosis of major depression. (PX 24, P 39). Dr. Swain found that being unable to work and the constant threat of divorce were "major stressors" for Petitioner along with chronic neck and back pain. (PX 24, P 39). Dr. Swain opined that Petitioner's severe depression started with his work injury of January 2, 2013. (PX 24, P 39). Dr. Swain opined that Petitioner was unable to tolerate employment for the foreseeable future. (PX 24, P 39). In a subsequent note dated September 30, 2019 Dr. Swain opined that Petitioner's severe depression "goes back before the fatty liver and lung nodule concerns" and that the physical pain from his back injury was the primary cause of his depression. (PX 24, P 53).

Petitioner's Exhibit 20 is a group exhibit of medical billing documents from Dr. Scott Glaser, CVS pharmacy, Counselor Victoria Te You Moore, Superior Ambulance, Dr. Swain and Chicago Health Medical Group. (PX 20). Petitioner is alleging $3,532.13 in outstanding medical bills. (ARB X 1).

The Arbitration hearing allowed the Arbitrator ample opportunity to personally observe Petitioner's subjective presentation and pain behaviors. The Arbitrator notes that Petitioner required multiple, lengthy breaks during questioning. The Arbitrator notes that Petitioner frequently winced, writhed in pain and demonstrated other behaviors suggestive of severe perceived and debilitating pain.

DEPOSITION TESTIMONY

Dr Thomas Gleason

Dr. Thomas Gleason was deposed on May 21, 2019. Dr. Gleason was identified as a board certified orthopedic surgeon who completed an independent medical examination of Petitioner on October 8, 2013. (PX 8, P 5, 7). Dr. Gleason testified that on physical examination no positive, objective findings were made. (PX 8, P 18). Dr. Gleason testified that the results of his physical examination did not correlate with Petitioner's subjective complaints of right lower extremity weakness. (PX 8, P 19). Dr. Gleason reviewed Petitioner's MRI films and found no evidence of neurological compression; the MRI did not correlate with Petitioner's complaints of right lower extremity weakness. (PX 8, P 20). Dr. Gleason testified that he reached one diagnosis that he attributed to Petitioner's January 2013 trauma: right low back pain in the absence of positive objective findings on physical examination. (PX 8, P 21).

Dr. Gleason testified that Petitioner was capable of full time work in at least a light level and that Petitioner's maximum work capacity would be performing his pre-injury work. (PX 8, P 25-26). Dr. Gleason testified that there was no objective orthopedic basis upon which light duty permanent restrictions would have been necessary for Petitioner. (PX 8, P 29).

Dr. Matthew Skarbek

Dr. Matthew Skarbek was deposed on January 14, 2019. Dr. Skarbek testified that he completed an independent medical examination of Petitioner on October 28, 2016. (PX 9, P 6-7). Dr. Skarbek testified that he arrived at three diagnoses following his review of Petitioner's records, his own clinic interview and his own examination and psychological assessment. (PX 9, P 18). Dr. Skarbek diagnosed Major Depressive Disorder recurrent with mild anxious distress, Somatic Symptom Disorder persistent and severe and Generalized Anxiety Disorder. (PX 9, P 18-19). Dr. Skarbek testified that Petitioner's diagnoses were not permanent in nature as Petitioner had not engaged in any consistent treatment. (PX 9, P 21). Dr. Skarbek testified that Petitioner's three DSM-V diagnoses were not caused or aggravated by the Petitioner's work accident of January 2, 2013. (PX 9, P 22). Dr. Skarbek based his opinion on the following, "Both from his statements and a review of the records, the conditions really developed sometime after that injury and after he had completed treatment for that injury, and really did not begin to develop or even present until after he was presented with information about other medical conditions that were unrelated to his back injury. (PX 9, P 23). Dr. Skarbek testified that Petitioner's psychological symptoms first manifested when Petitioner was diagnosed with lung nodules and fatty liver disease. (PX 9, P 23). Dr. Skarbek opined that Petitioner could return to work from a psychological standpoint. (PX 9, P 24). Dr. Skarbek testified that Petitioner required individual therapy, a health psychologist consultation and psychiatric treatment with medication management. (PX 9, P 33). Dr. Skarbek testified the need for future psychological treatment was not made necessary by Petitioner's physical injuries from January 2013. (PX 9, P 33-34).

Dr. Skarbek reviewed an office note from Dr. Brandt dated August 29, 2014 and testified that his own three diagnoses were the same diagnoses offered by Dr. Brandt. (PX 9, P 29-30). Dr. Skarbek testified that Dr. Brandt did not attribute any of those conditions to lumbar spine symptoms or complaints which was consistent with his own opinion. (PX 9, P 30).

Dr. Robert Sharpe

Dr. Robert Sharpe was deposed on December 4, 2018. Dr. Sharpe was identified as a psychiatrist who was retained by Petitioner's attorney to prepare a records review report. (PX 18, P 5, 7-8). Dr. Sharpe did not personally evaluate Petitioner despite the opportunity being offered by Petitioner's attorney. (PX 18, P 44). Dr. Sharpe did not complete a clinical interview with Petitioner, nor did he ever have an opportunity to make any behavioral observations. (PX 18, P 42). Dr. Sharpe testified that Petitioner was suffering from severe major depression which has disabled him substantially, if not totally, and that the depression was precipitated at least in part by Petitioner's work injury from January 2013. (PX 18, P 14). Dr. Sharpe testified that the work injury of January 2013 exacerbated Petitioner's depression over the summer of 2014 after treatment for the lower back had concluded. (PX 18, P 38). Dr. Sharpe testified that Petitioner's mental health condition would prevent him from engaging in vocational rehabilitation. (PX 18, P 15). Dr. Sharpe opined that Petitioner was totally disabled from working. (PX 18, P 16). Dr. Sharpe expressly testified that Respondent's examiner, Dr. Skarbek, would be in a better position to render an opinion on Petitioner's diagnosis and work capacity as Dr. Skarbek completed a clinical evaluation. (PX 18, P 40).

Dr. Sharpe testified that the first recorded complaint of a psychological condition was in June of 2014 approximately one and a half after the work injury. (PX 18, P 23). The first diagnosis of a psychological condition was from Dr. Brandt on August 29, 2014. Dr. Sharpe testified that the August 29, 2014 office note listed a myriad of subjective complaints, recent visits with multiple specialists and a number of recent diagnostic studies but did not identify any recent treatment or studies involving the lumbar spine. (PX 18, P 25 – 28).

Dr. Sharpe reviewed a psychological assessment completed by Dr. Dago on September 29, 2014 and testified that Petitioner's anxiety, depression or somatic issues were not attributed to the presence of low back pain. (PX 18, P 31).

Dr. Sharpe reviewed psychiatric records from Dr. Schwartz, also from September 2014, and testified that a diagnosis of generalized anxiety disorder was attributed to Petitioner's fatty liver and pulmonary nodules. (PX 18, P 34).

Dr. Sharpe agreed that in August/September 2014 three physicians (Dr. Brandt, Dr. Dago, Dr. Schwartz) diagnosed Petitioner with a psychological condition and none of the three physicians attributed Petitioner's psychiatric condition to his lower back injury or complaints of lower back pain. (PX 18, P 35).

Dr. Alexander Ghanayem

Dr. Alexander Ghanayem provided evidence deposition testimony on February 20, 2019. Dr. Ghanayem testified that he completed an independent medical examination of Petitioner on March 19, 2018. (PX 10, P 6). Dr. Ghanayem testified that his physical examination found no neurological deficits, full motor strength, no sensory loss and a negative straight leg raise for radicular pain. (PX 10, P 10-11). Dr. Ghanayem found positive Waddell signs suggesting nonorganic pain. (PX 10, P 12). Dr. Ghanayem testified that Petitioner's subjective complaints did not correlate with any physical examination finding or the results of Petitioner's MRI from January 2013. (PX 10, P 14-15). Dr. Ghanayem opined that Petitioner could return to his regular work. (PX 10, P 15).

Dr. Ghanayem testified that he reviewed films from repeat MRI completed on August 19, 2016. (PX 10, P 16-17). Dr. Ghanayem testified that after review of the MRI, his diagnosis of symptom magnification and his opinion that Petitioner could return to work at regular duty were unchanged. (PX 10, P 17-18).

Dr. Ghanayem testified that based on his examination and a review of treatment records and two MRI studies there was no evidence of any lumbar spine condition that could result in chronic pain, restrict Petitioner's ability to sit or stand for prolonged periods of time or inhibit Petitioner's ability to participate in a classroom setting. (PX 10, P 18-19).

Dr. Ghanayem testified that his diagnosis was symptom magnification and nonorganic pain behaviors; there was no structural issues that could be related to a low back work injury. (PX 10, P 12). Dr. Ghanayem testified that Petitioner required no further treatment. (PX 10, P 13).

VOCATIONAL EVIDENCE

Nancy Knapp was the first vocational counselor to work with Petitioner. Ms. Knapp prepared a Job Placement Plan on October 14, 2014. (PX 12). The goal of Ms. Knapp's plan was direct job placement with a new employer. (PX 12). The Plan was predicated upon the work abilities identified in the Flexeon Rehabilitation FCE of April 23, 2014 including a 10-pound lifting/carrying restriction. (PX 12).

Ms. Knapp completed a Labor Market Survey on March 27, 2015. (PX 14). The report was expressly limited to a very minimal level of function; employment positions at a sedentary level with lifting no greater than 10 pounds. (PX 14). The overall average wage for all employment available at this minimal level of function was $11.78 per hour. (PX 14).

Petitioner offered into evidence Exhibit #13 which was a compilation of vocational rehabilitation documents from Petitioner's work with Ms. Knapp between October 1, 2014 through July 20, 2015. (PX 13). The majority of the documents are job leads prepared by Ms. Knapp and job search logs completed by Petitioner. The job search leads from Ms. Knapp spanned a considerable wage range. Some positions like a Call Center Agent started at $9.00/hour (PX 13, P 13) but pay rates for other positions were considerably higher; Service Advisor, $60,000 - $100,000/year (PX 13, P 172), Customer Service Rep ($45,000 - $70,000/year) (PX 13 P 219), Automotive Service Advisor ($40,000 - $60,000/year) (PX 13, P171). The physical demand levels for the positions identified by Ms. Knapp did not exceed the sedentary-light level. (PX 13).

Ms. Lisa Helma was the second vocational counselor to work with Petitioner. An initial vocational assessment report was completed by Ms. Helma of Vocamotive on August 11, 2015. (RX 11). Ms. Helma opined that Petitioner had transferable skills based on his level of education and previous work experiences. Those skills applied to medical records/health information and mechanical/automotive occupations. (RX 11). Ms. Helma opined Petitioner was employable and that his wage earning potential would fall within a range of $10.00 - $15.00 per hour. (RX 11). Petitioner was deemed an appropriate candidate for vocational rehabilitation. (RX 11). The report was based on Petitioner' FCE results and assumed a sedentary level of function. (RX 11).

Ms. Helma's Rehabilitation Plan for Petitioner was entered into evidence as Respondent's Exhibit #12. The plan involved computer skills training (basic and advanced) and job seeking skill instruction. (RX 12, P 3). The plan was qualified upon Petitioner "manifesting meaningful behavioral commitment to (the) implementation of this agenda and participation in the crafting of future rehabilitation activities. (RX 12, P 5).

Ms. Helma provided Petitioner with a written warning about his effort and participation in the rehabilitation program dated August 24, 2015. The letter stated that Petitioner was taking excessive breaks and was not functioning consistent with his medical restrictions. (RX 13).

Petitioner was discharged from the Vocamotive program on September 9, 2015. Ms. Helma sent written confirmation and stated that the basis for terminating the vocational program was Petitioner's excessive breaks and Petitioner's behavior that did not correlate with his medical restrictions. (RX 14).

Petitioner made a formal request for reinstatement of vocational rehabilitation in a correspondence dated January 15, 2016. (PX 21).

Petitioner then sought a vocational assessment by Ms. Susan Entenberg at the request of Petitioner's attorney. Ms. Entenberg prepared a Vocational Rehabilitation Evaluation report dated September 14, 2017. (PX 15). Ms. Entenberg offered the opinion that Petitioner is not capable of performing his past work as a machinist based on his FCE results. (PX 15). Ms. Entenberg further opined that Petitioner was an appropriate candidate for vocational rehabilitation. (PX 15). Ms. Entenberg's opinions were predicated upon Petitioner functioning at a sedentary level with lifting, carrying and pushing limited to 10 pounds.

Ms. Entenberg opined that Petitioner maintained an earning capacity of $10.00 - $15.00 per hour based on his FCE restrictions in conjunction with his age, education and work history. (PX 15).

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

In support of the Arbitrator's decision relating to F (Is the Petitioner's current condition of ill-being causally related to the injury):

There is no dispute that Petitioner had a work accident on January 2, 2013. The Arbitrator finds that Petitioner suffered a very small disc protrusion at the L5-S1 level as a result of this accident. The Arbitrator finds that Petitioner reached maximum medical improvement on May 8, 2014. This low back condition is causally related to the injury.

This finding is based on the persuasive findings and opinions of Dr. David Fardon, Dr. Thomas Gleason and Dr. Alexander Ghanayem. All three orthopedic surgeons found that Petitioner reached maximum medical improvement no later than May 8, 2014. Petitioner did not engage in any meaningful lower back treatment from May 8, 2014 through the date of hearing.

The Arbitrator finds that there is no causal connection between any psychological condition that petitioner has and the work accident of January 2, 2013.

This finding is based on the findings and opinions of Dr. David Brandt, Dr. Lee Schwartz, Dr. Pedro Dago and Dr. Matthew Skarbek. There is also a lack of any temporal relationship between the treatment of Petitioner's physical lumbar spine injuries and the manifestation of any mental health condition/psychological injury. Indeed, it is also telling that Dr. Brandt's records also show that Petitioner reported "considerable sadness, nervousness and poor sleep for 5-6 years duration when he was seen on June 4, 2014.

There is no dispute that Petitioner suffers from various psychological conditions. There is a consensus among the mental health professionals who examined Petitioner that he suffers from Major Depressive Disorder, Generalized Anxiety Disorder and Somatic Symptom Disorder.

Petitioner's initial course of medical treatment for his lumbar spine injuries spanned from January 2, 2013 through May 8, 2014. During this time frame there was no recorded complaint consistent with any mental health condition. Petitioner did not treat with a psychologist, psychiatrist or counselor. Petitioner was not diagnosed with any mental health condition and was not prescribed any anti-depressant medication or other psychiatric medication. The first formal diagnosis of a mental health condition was by Dr. Bryant on August 29, 2014.

Dr. Robert Sharpe completed a records review, but never personally examined Petitioner. Dr. Sharpe testified that Petitioner's work injury of January 2013 "exacerbated" Petitioner's depression over the summer of 2014 after treatment for the lower back had concluded. (PX 18, P 38). In a note dated September 30, 2019, about two weeks prior to the Arbitration hearing, Dr. Swain found that Petitioner's severe depression "goes back before the fatty liver and lung nodule concerns" and that the physical pain from his back injury was the primary cause of his depression. (PX 24, P 53).

Conversely, Dr. Skarbek testified that the three DSM-V diagnoses he reached, Major Depressive Disorder recurrent with mild anxious distress, Somatic Symptom Disorder persistent and severe and Generalized Anxiety Disorder were not caused or aggravated by the Petitioner's work accident of January 2, 2013. Dr. Skarbek based his opinion on the following, "Both from his statements and a review of the records, the conditions really developed sometime after that injury and after he had completed treatment for that injury, and really did not begin to develop or even present until after he was presented with information about other medical conditions that were unrelated to his back injury. (PX 9, P 23). Dr. Skarbek testified that Petitioner's psychological symptoms first manifested when Petitioner was diagnosed with lung nodules and fatty liver disease.

The Arbitrator finds the opinions offered by Dr. Matthew Skarbek most comprehensive and persuasive on the issue of causal connection. The Arbitrator places emphasis on the fact that Dr. Skarbek's opinions are supported by the findings of Dr. Brandt, Dr. Dago/Northwestern Memorial Hospital and Dr. Schwartz between August and September 2014.

The first diagnosis of any mental health condition was offered by Dr. David Brandt on August 29, 2014. Dr. Brandt's office note goes to great lengths outlining the remarkable number of complaints and conditions that Petitioner was alleging along with the number of specialist consultations and diagnostic studies Petitioner had completed within the span of one month. Dr. Brandt found that Petitioner was "transfixed" upon having liver failure, diabetes, and multiple other illnesses. Petitioner was found to be "highly anxious" about his symptoms, and about liver diseases, and diabetes, requesting more glucose and hepatic function testing and a "fibroscan." (RX 4).

The Arbitrator notes that Petitioner's treatment between July 2014 and September 2014 involved a primary care physician, dermatologist, GI specialist, urologist, dietician, hepatologist and pulmonologist. During this time frame Petitioner never returned for evaluation with his orthopedic surgeon for lower back pain nor did Petitioner complete any physical therapy or pain management treatment.

In August 2014 Dr. Brandt notes that Petitioner had recently completed an EGD, lactulose hydrogen breath test, CT Scan of the abdomen/pelvis and diabetes screening. Petitioner was found to display "displeasure" about his tests being normal. (RX 4). Records from Northwestern Memorial Hospital also reflect the following studies: ultrasound of the liver (6/27/2014), ultrasound of the thyroid (6/27/2014), chest x-ray (9/8/2014), chest x-ray (9/13/2014), chest x-ray (9/29/2014), CT Scan of the brain (9/29/2014). (RX 15). Between July 2014 and September 2014 there is no evidence of any diagnostic study involving the lumbar spine.

Dr. Lee Schwartz completed an initial psychiatric evaluation on September 30, 2014. The handwritten note reflects a diagnosis of generalized anxiety disorder; the section of Dr. Schwartz's office note addressing this diagnosis references Petitioner's pulmonary nodules and fatty liver. (PX 7, RX 1).

Petitioner had three emergency room visits between August and September 2014. On August 5, 2014 the primary complaints involved gastrointestinal issues/complaints, but Petitioner reported anxiety as he was worried about cancer. The attending physician found that "There appears to be an anxiety component to his symptoms." (PX 6, P 165). On September 8, 2014 the primary complaint was shortness of breath. Petitioner's mental health was addressed, "PT reports he has been referred to a psychiatrist by his PMD but does not think he requires one; reports he is very concerned over potential health problems ***ever since he was diagnosed with fatty liver***. A degree of anxiety is likely contributing to pt's presentation." (PX 6, P 167 – 168) (emphasis added). The third visit was September 29, 2014 and Petitioner stated, "I don't know if the cancer spread from my stomach to my head." (PX 6, P 170). The attending physician, Dr. Malik, found evidence of major anxiety component and recommended a psychiatric assessment. An assessment completed by Dr. Pedro Dago. Dr. Dago found that Petitioner was "**somatically preoccupied since dx of fatty liver.**" (PX 6,P 70)(emphasis added). Dr. Dago found that Petitioner has "significant worry and fear of death in regard to lung nodules which he presumes is lung cancer. He associates other somatic experiences with a possible metastasis such as finger numbness or mild chest pain. His preoccupation with the symptoms has seemingly intensified over the past 1-2 months with several ED visits and multiple workups for complaints." (PX 6, P 75).

Dr. Randy Orr, Petitioner's pulmonologist found on September 19, 2014 that Petitioner was "highly anxious" about his pulmonary nodules and "frequently" requested that Dr. Orr "just cut out the nodules." (PX 6, P 65-66). Petitioner characterized his nodules as a "ticking time bomb" inside his chest. (PX 6, P 66). Dr. Orr noted that Petitioner was adamant about proceeding directly to surgery.

After diagnosing mental health conditions on August 29, 2014 Dr. Brandt saw Petitioner on multiple occasions in the months that followed. On September 10, 2014 Dr. Brandt found that Petitioner was transfixed upon his belching and epigastric pain/soreness and that he was "resigned to dying." On examination, Petitioner walked with a normal gait. (PX 6, P 62).

Dr. Brandt saw Petitioner on September 17, 2014 and reviewed abnormal findings from a CT Scan. Petitioner was "highly anxious about his hepatic steatosis, feels he will now die from lung cancer." (PX 6, P 63). Dr. Brandt found that Petitioner "perseverates on death due to cancer." (PX 6, P 65).

Perhaps most telling, on October 8, 2014 Petitioner denied back pain and, on examination, Dr. Brandt found that Petitioner was not tender to percussion and palpation; Petitioner had a normal gait. (PX 6, P 78).

Upon review of all treatment from the Summer of 2014 the Arbitrator finds ample support for the opinion offered by Dr. Skarbek that that Petitioner's psychological symptoms were related to Petitioner being diagnosed with lung nodules and fatty liver disease. There was no significant evidence of chronic and debilitating lower back pain; Petitioner denied back pain, had benign physical examinations and was not pursing any form of lumbar spine treatment.

The Arbitrator does not find evidence corroborating Dr. Sharpe's opinion that Petitioner's work injury of 2013 "exacerbated" Petitioner's depression over the Summer of 2014. Petitioner consistently attributed his symptoms to a liver and/or lung condition. The Arbitrator believes that any opinion offered on a mental health

condition, in the absence of ever questioning, examining or observing the patient's behavior personally is of questionable value. This point is seemingly shared by Dr. Sharpe, who conceded that Dr. Tzou and Dr. Skarbek would be in a better position to offer opinions on diagnosis and work capacity as they personally examined Petitioner. Dr. Sharpe's involvement was limited to a records review.

The Arbitrator does not find evidence corroborating Dr. Swain's finding that Petitioner's severe depression "goes back before the fatty liver and lung nodule concerns" and that the physical pain from his back injury was the primary cause of his depression. (PX 24, P 53).

The findings and opinions of Dr. Brandt, Dr. Schwartz, Dr. Dago and the Petitioner's own statements recorded by those physicians and by Dr. Orr and Northwestern Memorial Hospital during the Summer of 2014 consistently demonstrate that Petitioner's psychological injuries were the result of a "triggering event" in the form of being diagnosed with fatty liver and having lung nodules.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64, 442 N.E.2d 908, 911 (1982).

The Arbitrator finds particular support for the finding herein on the issue of causation in the opinion in *Bocian v. Industrial Comm'n*, 282 Ill.App. 2d 519 (1996) and the concept of "an unbroken chain" and "a triggering event" identified by the Appellate Court.

In *Bocian*, a firefighter claimant suffered a compensable accident involving left arm injuries and a subsequent accident resulting in a cervical disc herniation. *Bocian v. Industrial Comm'n*, 282 Ill.App.2d 519, 521 (1996). The claimant received a letter from the employer's workers' compensation carrier denying the second injury. The claimant pursued a disability pension and became distraught when he could not obtain the necessary medical evidence from his treating physician, Dr. Shea. *Id. at* 522. The claimant committed suicide approximately one month after receiving the denial letter. *Id.* at 521.

The medical professionals in *Bocian* concurred that the claimant suffered from major depression but there were conflicting opinions on whether that condition and the claimant's suicide were causally related to the work accident(s). *Id.* at 524-525.

The Appellate Court found that the claimant's suicide was causally related to his work-related injuries based on the following reasoning:

> *All the evidence in the record clearly, plainly and indisputably establishes that the onset of Ralph's major depression began no sooner than his work-related accident, particularly the accident of October 28, 1989. Likewise, the record indisputably establishes that Ralph's suicide was the product of this major depression, and more importantly, the letter from Dr. Shea was the "triggering event" which led to suicide. Since Dr. Shea's letter concerned the status of Ralph's work-related injury, it must be concluded that the "unbroken chain" of causation connected his work-related injuries to his suicide. Id.* at 529.

In applying the same reasoning to the present matter the Arbitrator finds that the record clearly and plainly establishes that the "triggering event" that lead to Petitioner's mental health conditions and multiple suicide

attempts was receiving a diagnosis of fatty liver and a finding of pulmonary nodules in the Summer of 2014. The diagnosis of fatty liver and the presence of pulmonary nodules have no relationship to Petitioner's work accident, such that the "unbroken chain" present in *Bocian* does not exist.

In support of the Arbitrator's decision relating to J (Has Respondent paid all appropriate charges for all reasonable and necessary medical services?):

The Arbitrator denies Petitioner's request for medical bills in the charged amount of $3,532.13.

For reasons previously enumerated the Arbitrator has found that Petitioner reached maximum medical improvement for his lumbar spine injuries on May 8, 2014. The Arbitrator has also found that no causal connection exists between Petitioner's psychological maladies and the work accident of January 2, 2013. The Arbitrator also finds that Petitioner has exceeded his two choices of medical providers allowed under Section 8(a) of the Act.

Based on the foregoing, the claim for medical bills offered into evidence as Petitioner's Group Exhibit 20 are denied.

In support of the Arbitrator's decision relating to K (Disputed TTD and Maintenance benefits):

The Arbitrator finds that Petitioner was temporarily and totally disabled from January 3, 2013 through May 8, 2014 when he was placed at maximum medical improvement by Dr. David Fardon. The Arbitrator awards Petitioner 70 1/7 weeks of TTD benefits, at a weekly rate of $1,154.61.

Petitioner was released with permanent work restrictions by Dr. Fardon that were not accommodated by Respondent. Petitioner participated in a vocational program with Ms. Nancy Knapp and Vocamotive that lasted through September 9, 2015 when Petitioner was discharged from the Vocamotive program for compliance issues. The Arbitrator awards Petitioner maintenance benefits from May 9, 2014 through September 9, 2015, representing 69 6/7 weeks, at a weekly rate of $1,154.61

Petitioner was interviewed by Ms. Susan Entenberg in September of 2017, but no formal vocational rehabilitation took place thereafter. Petitioner testified that he did perform any job search activities, training or formal vocational rehabilitation from September 10, 2015 through the date of hearing.

The Arbitrator finds no factual or legal basis to award either TTD or maintenance benefits after September 9, 2015.

Per the stipulation of the parties, Respondent is entitled to a credit in the amount of $162,799.82 for prior TTD and maintenance benefits.

In support of the Arbitrator's decision relating to L and O (What is the nature and extent of the injury? Is Petitioner entitled to benefits under Section 8(d)1 or Section 8(f)?):

Based upon the Arbitrator's findings on the issue of causation, above, an award under Section 8(f) or 8(d)1 is not appropriate and Petitioner's request for same is denied.

As the accident occurred on January 2, 2013, the Arbitrator is required to follow the dictates of Section 8.1(b) of the Act in determining PPD. 820 ILCS 305/8.1(b)

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 rendered by Dr. Thomas Gleason, who found 1% PPI.in this case. This factor is given appropriate weight in determining PPD.

2. Petitioner's occupation
   On the date of the accident, Petitioner was a Machinist engaged in repairing garbage trucks for Respondent. He was not able to return to work in his usual and customary position without restrictions. This factor is given great weight in determining PPD.

3. Petitioner's age at the time of injury
   Petitioner was 37 years old at the time of injury, and he is 44 years old at the time of the hearing. This is relevant and should receive some weight in determining PPD.

4. Petitioner's future earning capacity
   Petitioner has no loss of earning capacity that can be related to the injury according to the proofs. Vocational evidence does not necessarily establish a loss of earning capacity, as Petitioner's vocational rehab program was terminated due to behavioral issues not related to the injury. Moderate weight is placed on this factor.

5. Petitioner's evidence of disability corroborated by medical records
   As a result of the work injury, Petitioner underwent conservative treatment for his low back injury, with significant deficits being shown, per the FCE results and Dr. Far. This factor is given much weight in determining PPD.

After considering the above, and the Record as a whole, the Arbitrator finds that the injuries sustained caused Petitioner to suffer the 30% 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	19WC010098
Case Name	HOWELL, JERRY v. STATE OF ILLINOIS BIG MUDDY RIVER CORRECTIONAL CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0393
Number of Pages of Decision	10
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Aaron Wright

DATE FILED: 8/4/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Howell,

Petitioner,

vs. NO. 19WC 10098

State of Illinois/Big Muddy River Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the 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 January 8, 2021 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

August 4, 2021

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

SJM/sj
o-7/13/2021
44

/s/*Deborah Simpson*
Deborah Simpson

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0393
NOTICE OF ARBITRATOR DECISION

HOWELL, JERRY
Employee/Petitioner

Case# **19WC010098**

ST OF IL/BIG MUDDY RIVER CORRECTIONAL CENTER
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:

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

0558 ASSISTANT ATTORNEY GENERAL
AARON WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICS
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
SPRINGFIELD, IL 62794

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

JAN -8 2021

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Jerry Howell
Employee/Petitioner

v.

State of Illinois/Big Muddy River Correctional Center
Employer/Respondent

Case # **19** WC **10098**

Consolidated cases: _____

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Mt. Vernon, Illinois**, on **October 9, 2020**. By stipulation, the parties agree:

On the date of accident, **March 3, 2019**, 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 but only as to an exacerbation of any pre-existing PTSD/mental health claim.

In the year preceding the injury, Petitioner earned $**77,512.50**, and the average weekly wage was $**1,490.62**.

At the time of injury, Petitioner was **49** years of age, ***single*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been **or will be** provided by Respondent.

Respondent shall be given a credit of $**All paid** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**103,007.28** for extended benefits, for a total credit of $**103,007.28**.

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

ORDER

Respondent shall pay Petitioner the sum of **$813.87**/week for a further period of **50** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **10%** loss of Petitioner's **person as a whole** as a result of serious and permanent injuries sustained to Petitioner's **mental health/PTSD**, and the sum of **$813.87**/week for a further period of **37.575** weeks, as provided in Section **8(e)11** of the Act, because the injuries sustained caused **22.5%** loss of Petitioner's **right foot** as a result of serious and permanent injuries sustained to Petitioner's **right ankle**.

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

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

Signature of Arbitrator

12/16/20
Date

ICArbDecN&E p.2

JAN -8 2021

STATE OF ILLINOIS)
) **SS**
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
Nature and Extent Only

JERRY HOWELL,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 19-WC-10098
	)	
STATE OF ILLINOIS/BIG MUDDY RIVER CORRECTIONAL CENTER,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Mt. Vernon on October 9, 2020. On April 3, 2019, Petitioner filed an Application for Adjustment of Claim alleging injuries to his right foot, ankle, leg, and alleged he suffered PTSD, anxiety, and stress as a result of the accident. The parties agreed that on March 3, 2019, Petitioner was employed as a Correctional Food Service Supervisor for Respondent when he sustained injuries as a result of an inmate assault. The only issue in dispute is the nature and extent of Petitioner's injuries. All other issues have been stipulated.

TESTIMONY

Petitioner was 49 years old, single, with one dependent child at the time of accident. Petitioner worked for Respondent for 27 years at its Big Muddy River Correctional Center facility and is presently retired. On March 3, 2019, Petitioner was a Correctional Food Service Supervisor working in dietary. He and his assigned inmates were disposing of trash when a dispute arose among the inmates. An inmate punched Petitioner in the chest and six or seven inmates attacked him while he was on the ground. Petitioner was able to locate his radio and glasses that were lost during the attack and defended himself while he called for assistance.

Petitioner testified he felt immediate pain in his right ankle. He experienced swelling, loss of strength, loss of range of motion, and he walked with a limp. He testified that his right foot just "hung there" and he had little control of his foot and could not move it. He underwent right ankle surgery in June 2019 which significantly improved his symptoms. Dr. Bradley released him to full duty work on 2/20/20.

After undergoing surgery and completing physical therapy, Petitioner testified he was doing "very good". He was happy with the surgical results as he was homebound and ambulating with great difficulty in a walking boot prior to the surgery. He still has some soreness in his ankle with overuse and takes over-the-counter Tylenol and Aleve to control his symptoms. He is now able to walk for prolonged distances where he was unable to do so following the accident. He experiences aches, pain, and pressure in the ankle joints with weather changes. Petitioner testified he takes between 500 to 1000 milligrams of Tylenol and Aleve a day when performing household chores, cleaning up dog kennels, dog training, and hauling feed.

Petitioner testified that the attack caused his nightmares and sleep paralysis to return. He testified he sustained physical injuries in March 2009 from being attacked by an inmate and was diagnosed with PTSD, depression, restlessness, and anxiety as a result of that incident. Petitioner testified he sought treatment for his prior conditions and was able to return to full duty work. Following his March 2019 accident, Petitioner was referred to Rea Clinic for a reoccurrence of his PTSD symptoms but he was not able to be seen for three months. Petitioner testified he suffered from PTSD, anxiety, and stress following the accident. He experienced loss of sleep, sleep paralysis, and frequent nightmares. Petitioner was withdrawn from his personal relationships and did not want to leave his house. He kept seeing movement in his peripheral vision and became fearful of another attack. He testified that it got to the point where he could not sleep in his bed because he felt like someone was lying in bed with him or sitting next to him. Petitioner stayed up all night in the house with the lights on, and when he slept, he did so in a recliner, or he would sleep outside. Petitioner was constantly fearful for his life. He testified his PTSD symptoms were more severe following his 3/3/19 accident than after his March 2009 attack and he never required a service dog prior to 3/3/19.

Following psychiatric treatment and therapy, as well as the use of a prescribed service canine, his condition began to improve. His service canine wakes him during his sleep paralysis and calms him when he has panic attacks. Because of the use of his support canine, he focuses his attention on his dog, feels grounded by her and is not afraid of sudden movements and is not fearful of people attacking him. Petitioner still takes note of his exits and entrances whenever he is out. He is always mindful to "pick a safe place" whenever eating out. Petitioner is trying to normalize his relationships and open himself up to other people again. He testified he still suffers approximately two to three panic attacks per month but has improved since the accident when he would have weekly panic attacks or experience them every other day. The panic attacks are triggered by being in closed spaces, being without his service canine, and being in crowded areas. Petitioner's service dog was present with him in the hearing room at all times.

MEDICAL HISTORY

Petitioner presented to Express Care of Mt. Vernon following the accident. He reported pain and swelling in his right ankle and had an abrasion on his right knee. A history of accident was noted. X-rays revealed lateral soft tissue edema and were otherwise unremarkable. On 3/6/19, Petitioner was seen by Physician's Assistant Carmella Doss at Christopher Greater Area Rural Health for his right ankle and anxiety. A consistent history of the accident was reported and it was noted that Petitioner was ambulating with the use of a crutch. He had also been icing and elevating his foot as well as using an ACE wrap and rotating between Ibuprofen and Tylenol

Dr. Kosmicki administered a number of psychological tests, which indicated significant symptoms and mental health problems that were likely influencing his ability to function. The Minnesota Multiphasic Personality Inventory indicated Petitioner was currently in emotional distress and may be in crisis. Dr. Kosmicki noted that Petitioner's symptoms were related to paranoia which was most likely associated with pervasive personality factors and acute factors related to PTSD. Findings from additional tests indicated high levels of distress, paranoia, and depression. It was noted that Petitioner was likely to have a much slower recovery than other patients. Dr. Kosmicki stated that Petitioner was experiencing significant distress and PTSD symptoms associated with a recent assault by an inmate at his place of work and complicated by past trauma and personality disorder. Dr. Kosmicki believed Petitioner would benefit from additional counseling, including pre-surgical counseling, with a qualified mental health provider with experience working with trauma and post-traumatic stress disorder. Petitioner was to follow up with him on 8/3/19.

On 6/26/19, Petitioner underwent a right ankle modified Brostrom procedure utilizing a gracilis allograft, arthroscopic chondroplasty of the anterolateral aspect of the talus, and internal fixation of the talus.

On 7/18/19, Petitioner began treating with Sallie Schramm for therapy and counseling. He treated with Ms. Schramm several times monthly until he was released on 1/7/20. Petitioner also continued to treat with Dr. Kosmicki monthly until 1/27/20 at which time he was released at significant improvement. Following surgery, Petitioner was kept off work and subsequently resumed physical therapy on 9/17/19 through 10/14/19.

On 1/28/20, Petitioner was evaluated by Dr. Stacey Smith pursuant to Section 12 of the Act. Dr. Smith testified by way of evidence deposition on 7/23/20. Dr. Smith's testimony was consistent with her report and opined that Petitioner may have aggravated a pre-existing anxiety/post-traumatic condition. She testified that Petitioner was ready, willing, and able to seek full-time employment. Dr. Smith opined Petitioner had reached maximum medical improvement.

Petitioner was released by Dr. Bradley to return to full duty work with respect to his right ankle and reached maximum medical improvement on 2/20/20.

CONCLUSIONS OF LAW

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:** With regard to this subsection, the Arbitrator notes that neither party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation:** The Arbitrator notes that Petitioner retired from his employment with Respondent and currently spends his time volunteering training service canines. The Arbitrator gives no weight to this factor.

(iii) **Age:** The Arbitrator notes Petitioner was 49 years of age at the time of the accident. While Petitioner has retired from employment with Respondent he has a significant number of years to live and potentially work with his injuries. The Arbitrator, therefore, places some weight on the factor.

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity contained in the record. Petitioner no longer works in the correctional setting and has not worked for Respondent since the accident. Although he voluntarily retired, Petitioner is 51 years of age and requires a service canine with him at all times as a result of his PTSD diagnosis. It is unlikely he could perform his work duties for Respondent without the aid of his canine. The Arbitrator, therefore, places some weight on this factor.

(v) **Disability**: The Arbitrator notes that Petitioner was a credible witness. He underwent a right ankle modified Brostrom procedure utilizing a gracilis allograft, arthroscopic chondroplasty of the anterolateral aspect of the talus, and internal fixation of the talus. Despite being released at maximum medical improvement without restrictions, Petitioner continues to report symptoms in his ankle, including pain and soreness with daily activities and with weather related conditions which require over-the-counter medications. With respect to Petitioner's mental health condition, Petitioner still suffers from occasional panic attacks, symptoms of withdrawal in personal relationships, dependence on the assistance of his service canine, sleep paralysis, and fearfulness. Petitioner's daily activities increase his ankle pain and requires rest and over-the-counter medications.

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 10% person as a whole pursuant to section of 8(d)2 of the Act, and 22.5% of the right ankle pursuant to section 8(e)11 of the Act.

Linda J. Cantrell

Arbitrator Linda J. Cantrell

12/16/20

DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC000604
Case Name	WALLACE, SHARON (WIDOW) v. STATE OF ILLINOIS DEPT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0394
Number of Pages of Decision	27
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Mark DePaolo
Respondent Attorney	Joseph Blewitt

DATE FILED: 8/4/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sharon Wallace, Widow of Norman Wallace, Deceased

Petitioner,

vs. NO. 15 WC 604

State of Illinois, Department of Transportation,

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(s) of accident, medical expenses, permanent disability, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2021 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

August 4, 2021

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

SJM/sj
o-7/13/2021
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/s/ *Deborah Simpson*
Deborah Simpson

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0394

WALLACE, SHARON WIDOW OF WALLACE, NORMAN DECEASED Case# **15WC000604**

Employee/Petitioner

ST OF IL DEPT OF TRANSPORTATION

Employer/Respondent

On 1/21/2021, 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:

0233 DePAOLO & ZADEIKIS
MARK A DePAOLO
309 W WASHINGTON ST SUITE 550
CHICAGO, IL 60606

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 BUREAU OF RISK MANAGEMENT
801 S 7TH ST
6TH FL
SPRINGFIELD, IL 62794

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

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

JAN 21 2021

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sharon Wallace, Widow of Norman Wallace, Deceased Case # 15 WC 0604
Employee/Petitioner

v.

State of Illinois, Dept. of Transportation
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 **October 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

S. Wallace, Widow, v. SOI, Dept. of Transportation, 15 WC 0604

FINDINGS

On **January 21, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Decedent's death ***is*** causally related to the accident.

In the year preceding the injury, Decedent earned **$79,528.00**; the average weekly wage was **$1,529.38**.

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

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

No benefits have been paid as a result of this claim.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $31,583.75, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay death benefits, commencing January 22, 2013, of $1,019.59 per week to the surviving spouse, *Sharon Wallace*, until *$500,000 has been paid or 25 years*, whichever is greater, have been paid, because the injury caused the employee's death, as provided in Section 7 of the Act.

If the surviving spouse remarries, Respondent shall pay the surviving spouse a lump sum equal to two years of compensation benefits; all further rights of the surviving spouse shall be extinguished.

Respondent shall pay *$8,000* for burial expenses to the surviving spouse, as provided in Section 7(f) of the Act.

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

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

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

Signature of Arbitrator

January 21, 2021
Date

JAN 21 2021

FINDINGS OF FACT

Testimony of Sharon Wallace

Sharon Wallace is the widow of Decedent, Norman Wallace ("Wallace"). They were married on June 22, 1982. (PX 6) They had 2 children, both daughters, who were both over the age of 18 years old on January 21, 2013, the date of Norman Wallace's death.

Norman Wallace was scheduled to be off of work on January 21, 2013 (it was Martin Luther King Day). He received a call early on that morning, possibly about 6 a.m., to come to work due to the inclement weather. Mrs. Wallace recalls the day as being extremely cold and blustery with blowing snow. After Mr. Wallace left to work that day, she did not hear from anyone after that until 11 a.m. At that time, she received a phone call from a Mr. Giglio, who was Mr. Wallace's supervisor. Giglio told her that an ambulance had been called and Norman was sweating and had shortness of breath and was being taken to South Suburban Hospital. Mrs. Wallace called one of her daughters and left for the hospital. When she arrived there, she was told to wait in the waiting room. The doctor came out and got her at about 12 p.m. and told her that Mr. Wallace passed away.

Norman Wallace was a big man; his lifestyle was sedentary in nature. He was 55 years old at the time of his heart attack. His hobbies were cooking and sometimes fishing. Mrs. Wallace has not remarried since the time of Mr. Wallace's death.

Mrs. Wallace paid hospital and doctor bills (Petitioner's Exhibits No. 3, 4A, 4B) as well as Mr. Wallace's cremation bill (Petitioner's Exhibit 5). She used money from her husband's life insurance policy in order to pay these bills.

Statement of Witness Jim Giglio

Jim Giglio was Norman Wallace's supervisor on January 21, 2013. His statement was admitted into evidence as Petitioner's Exhibit No. 9. Per his statement, Mr. Giglio was in constant contact with Mr. Wallace on their personal cell phones that morning attempting to assist Wallace with proper staffing to handle a storm.

Per Mr. Giglio, Wallace was very upset with the staffing level and was asking for more employees. Mr. Giglio called other employees that morning and also gave Wallace permission to add staffing. At about 10:25 a.m., Mr. Giglio received a call from Wallace saying that there was an equipment failure and that a plow had fallen off a truck. Mr. Giglio attempted to calm Wallace as he was still upset with the morning's staffing situation. He told Wallace to make sure that a TMA was taken to ensure the safety of the public and for the staff on the scene. At about 11:25 a.m., Mr. Giglio received a call from a mechanic, Mark LoBue, who stated that he believed Wallace was having a heart attack and that he had called 911. Thereafter, Mr. Giglio went to the emergency room at the hospital and was allowed to see Wallace. Wallace saw Mr. Giglio and called to him. Mr. Giglio said that Wallace looked very scared. Mr. Giglio was moved out of the room by hospital personnel. Within a few minutes, Giglio heard an intercom call for Code Blue. Mr. Giglio went back to security and tried to see Wallace. The doctor came into the room and informed Giglio and Mrs. Wallace that her husband had passed away.

Statement and Testimony of Ed Resnick

Ed Resnick, a co-worker of Norman Wallace, was called by Petitioner, via evidence deposition. His testimony is contained in both Petitioner's Exhibits No. 10 (Statement) and Petitioner's Exhibit No. 11 (Deposition of Ed Resnick).

Ed Resnick has been working for the Illinois Department of Transportation since 2009. His job title is Highway Maintenance. The general work tasks of a highway maintenance person are to maintain the highway with repair of bridges, sewers, guard rails , pot holes, pick up debris, mow the grass and, in the winter time, plow and salt the roadway. (Resnick Deposition, pg 6)

Resnick was on the job on January 21, 2013. The workers had been called out to do snow plowing and salting of the highway. Wallace was his supervisor that day. Wallace assigns the personnel to their individual highway route to plow and salt the highway. This was a holiday. (Resnick Deposition pg 6)

Mr. Resnick and Wallace had a good working relationship; they had never associated socially but had worked together well for several years. They both had military experience and kidded each over the years about the differences between Marine and Army personnel. (Resnick Deposition, pg 8)

On January 21, 2013, Resnick went to work about 6:30 a.m. It was still dark when he went to work and it was extremely cold, maybe 10 degrees. It was blowing snow and icy conditions and that is why they had called him in to work that day. His job that day was to plow and salt the roadway so that the roadway could stay open. Mr. Resnick was driving a 6-ton dump truck with a salt-spreader on it. It also had a plow on the front which measured approximately 11 feet wide by 5 feet high. (Resnick Deposition, pg 9)

Mr. Resnick was plowing on I-57. As he drove across a bridge that overpassed Interstate 80, the plow on the front of his truck disengaged and the plow started sliding down the highway in front of his truck. (Resnick Deposition, pg 10)

Mr. Resnick was able to partially push the plow off the roadway. However, the plow was still partially on the roadway as was the truck. This was occurred about 10:30 a.m. (Resnick Deposition, pg 11)

The situation was dangerous to the public. The truck was still on the highway and it was disabled, so it could not be moved. In addition, the highway was not being plowed and salted at that point. (Resnick Deposition, pg 12)

He was not able to mark any warnings or lights with regard to the obstruction. **"All I could do at that time was turn on all the hazard lights on the truck."** He immediately radioed to his supervisor, Wallace. He described the situation to Wallace. Visibility on the highway at that time was poor, it was blowing snow. It was also slippery. It was a very dangerous condition for motorists, as this section of highway of was curved. (Resnick Deposition, pg 13)

Within approximately 5-10 minutes of his radio call to Wallace, Wallace arrived at the scene of the disabled truck. Wallace's demeanor was upset. Wallace came sliding to a stop. **"I mean, he came in there fast and slammed on the brakes and jumped out of the truck. I got out of the truck and he started walking towards me."** (Resnick Deposition, pg 14)

In analyzing the situation, Wallace and Resnick felt that they could not cut the plow off the truck because the hydraulic fluid would leak all over the highway. They needed to call a mechanic to come out and work on the truck. Wallace got on his phone and called a mechanic, Mark LoBue, and told him **"get his ass to work as soon as he could."** They did not sit around for LoBue to show up. As soon as Wallace got off the phone with LoBue he said **"we are going to have to go to the yard to get a TMA."** A TMA is a traffic control light box that hooks onto the back of a plow truck. It can make a lighted arrow board to either the right or the left along with caution instructions. It also has a light caution bar on it to slow traffic down. It's a big flashing sign. It's about 6 feet by 10 feet. A TMA also has energy absorbing crash protection boxes on the back of it in case it is struck by a motorist. (Resnick Deposition, pgs 16-17)

Mr. Resnick and Wallace got into Wallace's truck. They went to their yard, which was the I-57 yard. When they got close, Wallace instructed Resnick to get another truck out of the building and to meet him in the area where the TMA units were stored. Resnick got into a dump truck and began to back it toward the TMA. Wallace had already gone to the back of the yard and was ready to guide the dump truck to the TMA. Resnick got out of the truck and started to walk to the back of it. Wallace was already lowering the bar onto the connection pin. This is done by manual cranking. **"What you do is you have a big crank handle on the top of the TMA. You physically have to crank, to take that crank handle, crank it round and round to lower that TMA onto what they call a pintle hook."** Wallace was doing the cranking. He had started doing the cranking prior to Mr. Resnick even getting out of the truck. He was just finishing up doing the cranking when Mr. Resnick was walking back towards the TMA. **"Norm was using both hands, ok, and physically using his whole body to crank that trailer down"** .... **"it was cold outside, probably had been sitting outside at least two weeks. The lube inside that worm gear was frozen so it took quite a bit of effort to lower that trailer down."** (Resnick Deposition, pgs 19-20)

Wallace was a big man. He was 6'1" or 6'2". He was using two hands to crank that board down. **"Using both hands. Basically using his whole body to crank..... because you could see how he was shifting his weight on one leg and then when it came around, he would be shifting his weight....pulling**

and pushing to get that bar down." This was obviously difficult for him to do. (Resnick Deposition, pgs 20-21)

The TMA unit has two hydraulic stabilizers that must be hooked up to the truck. They are big hydraulic cylinders. They're probably approximately 5 feet long each. There is a push rod and a piston inserted into each of them. The push rod or piston must be pulled out and positioned to the attachment point and the pin inserted in order to connect the TMA to the truck. (Resnick Deposition, pgs 21-22)

The hydraulic cylinder probably weighs 50 lbs. You are at a disadvantage trying to lift it up because you are underneath the back of the truck. The piston was very difficult to get out at that time because of the weather. It was about 10 degrees outside, so that hydraulic fluid **"is pretty much like lard."** (Resnick Deposition, pg 22)

The pistons attach to the framework on the underneath of the truck. You have to get under the frame of the truck in order to attach them. That space is about 3.5 feet or 4 feet tall at the most. The whole process is done manually. Employees are routinely told that this is a 2-person job; one person has to lift up the cylinder physically and the other man pulls the piston out to align it with the attachment. (Resnick Deposition, pg 23)

Wallace was bent down and Resnick was trying to hold the cylinder. Wallace **"was trying with all his might pushing, pulling, yanking, trying to get that piston out of the cylinder."** It took him 5 minutes to do the first cylinder. He was tugging, pushing trying to get the cylinder out. The cylinder was extracted and had to be lined up with the back of the truck and had a 1" in diameter by 6" linch pin go through the cylinder and through the connections in the back of the truck. Wallace used a 10-15 lbs. ball peen hammer, and was bending down and trying to hammer the pin in. **"It was so cold everything was frozen up."** Wallace had a difficult time pounding the pin in. It took 5-7 minutes to get one cylinder in and then the other side had to be done. Wallace kind of did most of the labor on the 2nd cylinder also. (Resnick Deposition, pg 25)

Mr. Resnick then identified photographs of the same type of truck, and, possibly even the same truck, that they were working on that day in order to get the TMA unit attached. The photographs depict an employee of a much smaller stature than Wallace underneath the truck in the position that Wallace was in. Mr. Resnick

again explained the difficulty with this process. **"[Wallace] just wasn't using his hands, arms; he was using the strength of his whole body to try and attempt to get that piston out. Yanking, pulling on it to do whatever he could to get it extended."** (Resnick Deposition, pg 30)

When Wallace exited from out underneath the truck he looked exhausted. **"[Wallace] looked winded, ok, he was slouched down a little bit, you know, had a –when he told me he wanted me to take it out, he would, in his words, he said, Eddie, I need, kind of breathing hard, I need you to go out, you know, and then stop, get his breath again, go out on the highway immediately with the TMA."** (Resnick Deposition, pg 30)

Wallace looked exhausted; he was leaned over and he **"had a little paleness on his face, he looked like he had just been worked out for, you know, 5, 10 minutes."** (Resnick Deposition, pgs 30-31)

Mr. Resnick noticed Wallace's breathing. **"Just his breathing. He didn't talk in a complete sentence. He told me what to do, stop, take a breath…I need you to go out on the highway… and stop and get a breath… immediately…he was trying to catch his breath."** (Resnick Deposition, pg 31)

Resnick then left the yard at about 11 a.m. to get the TMA out ot the disabled truck. Mr. Resnick gave a written statement, which was identified as Petitioner's Exhibit No. 10. After Mr. Resnick had left the yard to go out to Highway 57 to guard the disabled truck with the TMA, he had a phone call from the mechanic, Mark LoBue. This is the mechanic who had been scheduled to meet Wallace at the yard. Mr. LoBue told him that he believed that Wallace was having a heart attack and that he had an ambulance on the way. This was about ½ hour after Mr. Resnick had left Wallace at the yard. Later that day he received a call from the supervisor, Jim Giglio. He was told of Wallace's death at that time. (Resnick Deposition, pg 36)

During the time of these events, the IDOT workers feared "losing the highway." Losing the highway means when the snow is coming down, the drifting and icy conditions are so bad that you cannot keep the highway open for the motoring public. The highway becomes unsafe. It is likely that there will be vehicle accidents if the workers do not stay ahead of the situation. (Resnick Deposition, pg 37)

Mr. Resnick again identified his statement which says that Wallace **"started violently yanking, pushing, pulling and hammering with all his might."** Those are his exact words when making the statement. Resnick then confirmed that when Wallace came out from under the truck, that he was **"visibly out of breath and it looked like he was exhausted."** (Resnick Deposition, pg 38)

Testimony of Mark LoBue

Mark LoBue works as an auto mechanic for IDOT. His statement was admitted into evidence as Petitioner's Exhibit No. 8. His received a call from Wallace to come to work to repair a downed vehicle on the I-57 roadway. He arrived at the yard at approximately at 11 a.m. He saw Wallace in the hallway near Wallace's office. Wallace asked LoBue to take his truck out to the disabled vehicle on I-57. He also said that **"something was not right at the base of his throat"** and that he **"was light-headed."** Wallace also said that he was dizzy and that he had sweating and pressure. Mr. LoBue called 911. Within 5 minutes, an ambulance arrived and transported Wallace to South Suburban Hospital.

Weather Report

Petitioner's Exhibit No. 13, United States Certified Climatological Report. The report shows that at the time and the place of the occurrence it was 11 degrees Fahrenheit, with wind chill factors well below zero degrees, Fahrenheit.

Testimony of Dr. Schneeberger

Evidence from Dr. Schneeberger was submitted by report (Petitioner's Exhibit No. 14) and deposition (Petitioner's Exhibit No. 15). Dr. Bill Schneeberger began his residency in 1985 and was board certified in cardiothoracic surgery in 1990 in South Africa. Up until 2015, he had an active medical practice as a cardiothoracic surgeon. He did his fellowship in the Department of Thoracic Surgery affiliated with Ohio State University. Dr. Schneeberger has numerous publications with regard to cardiovascular disease, cardiovascular surgery, and cardiovascular dysfunction and cardiovascular rehabilitation. In 2018, Dr. Schneeberger was

retained by former counsel for Petitioner to review certain records regarding Wallace, which ultimately resulted in a report dated July 30, 2018. (Dr. Schneeberger Deposition Pg. 11)

Dr. Schneeberger also listed the records that he reviewed in preparation for his report as well as his testimony as follows:

- Ambulance log from Bud's Ambulance Service dated January 21, 2013 regarding Norman Wallace (Petitioner's Exhibit No. 1)
- Advocate South Suburban Hospital records of January 21, 2013 (Petitioner's Exhibit No. 2)
- Co-employee statements (Petitioner's Exhibits 8, 9, 10)
- Wallace's Death Certificate (Petitioner's Exhibit No. 7)
- Climatological records which show the temperature when and where Wallace was working (Petitioner's Exhibit No. 13)

(Dr. Schneeberger Deposition, Pgs. 12, 13)

It is Dr. Schneeberger's opinion that Norman Wallace sustained a fatal myocardial infarction on January 21, 2013, which is in agreement with the Death Certificate.

Dr. Schneeberger assumes, for purposes of his report and his testimony, that Norman Wallace smoked cigarettes prior to his death. He attributed significance to cigarette smoking as follows:

> **"I think smoking has been clearly found to have an influence on myocardial health in that it has been shown to accelerate atherosclerosis or hardening of the arteries in both the cardiac vessels and peripheral vessels in the majority of patients."** (Dr. Schneeberger Deposition, pg. 16)

Per his medical records, Wallace had never had a history of angina or chest pain. However, Dr. Schneeberger did find, per Wallace's recorded body mass index of 36.9, that Wallace was obese, not morbidly obese, but simply obese. This would have a role in the development of cardiovascular disease. (Dr. Schneeberger Deposition, pg. 18)

Dr. Schneeberger had a basic, clear understanding of the events of the day of January 21, 2013 as follows:

> **"....he was out in the yard adjacent to the salt dome and they were trying to attach a TMA to a vehicle. A TMA appears to be some sort of warning sign that would improve the safety of both the Illinois road department as well as the public using the road. Evidently there were some heavy metal pistons which need to be aligned to some slots in a truck and these had frozen because of the intense cold weather and Mr. Wallace seemed to be manhandling**

> **this thing into position. And the quote that I have from Mr. Resnick is, "he was violently yanking, pushing, pulling and hammering with all his might. So Wallace appeared to be ...and, in addition, it was said that he was a large man working in cramped and cold conditions."**
> (Dr. Schneeberger Deposition, pgs. 20-21)

When asked if the positioning of Wallace at the time of his exertion was significant, Dr. Schneeberger opined as follows:

> **"You got two types of exercise, you have isometric and dynamic exercise. When you're in a cramped condition where you're not able to move, that becomes isometric exercise. Both isometric and dynamic exercise have been shown to increase your cardiac risk in cold weather..."**

Dr Schneeberger commented on the temperature at the time that Wallace was performing strenuous exercise as follows:

> **"Correct, the climatological report was provided for me and there are a number of different pages in the report, but on page 6 and page 19, the temperature was 11 degrees Fahrenheit with a wind speed of 18 gusting at 25 which gave wind chill factor of -8 degrees Fahrenheit."**

Dr. Schneeberger disregarded the wind chill in his opinions regarding temperature:

> **"The significance of the temperature has been shown multiple times. The lower the temperature gets, the more prone you are to have cardiac manifestation in the form of myocardial infarction or angina."** (Dr. Schneeberger Deposition, pgs. 22-23)

The records indicate that Wallace's diagnosis was given as "acute myocardial infarction and cardiogenic shock" upon his arrival at the hospital. The ambulance crew had called ahead for a cardiologist to be available for consultation upon the arrival of the ambulance.

Further review of records by Dr. Schneeberger indicated that Wallace had a complete obstruction of the right femoral artery with heavy collateralization noted from the left side to the right side. That means under ordinary circumstances the right coronary artery had been diseased for some time and had already started to draw blood from the left coronary artery. Under normal circumstances, this would not lead to any symptoms.

> **"Absolutely. In fact, in my experience, I've encountered many patients who have had either total obstruction or very tight narrowing of the right coronary artery and they've been absolutely unaware of it."** (Dr. Schneeberger Deposition, pg. 30)

Dr. Schneeberger opines with regard to some of the occupational factors contributing to Wallace's MI as follows:

Extreme cold weather:

> **"Well, the primary, was that it's long been known that people with coronary artery disease should avoid extremes in temperature, because both very cold and very hot environments increase the work load on your heart...Yes, and I listed a number of studies to support the statement."** (Dr. Schneeberger Deposition, pg 36)

and further:

> **"Yes. In fact, the one that I quoted you from the European Heart Center was that for each 10 degrees, centigrade this is, for each decrease of 10 degrees centigrade, there is a 9% increase in the risk of acute myocardial infarction."** (Dr. Schneeberger Deposition, pg 37)

Dr. Schneeberger believed that Wallace had a long-standing problem with his right coronary artery. This problem had been there for a long time. Wallace had never complained of any chest pain or angina or even a shortness of breath. Dr. Schneeberger would call this a predisposing condition for heart attack. (Dr. Schneeberger Deposition, pgs 37-38)

Dr. Schneeberger's opinion with regard to causation is best summarized as follows:

> **"My opinion is that Mr. Wallace had just engaged in some extremely strenuous work that was not usual or ordinary for him in a very cold environment which led to a massive increase of workload on his heart which then precipitated his myocardial infarction. I think that the strenuous work definitely played a role in accelerating his myocardial infarction."** (Dr. Schneeberger Deposition, pg 42)

Testimony of Jeffrey Soble, M.D.

Dr. Jeffery Soble was retained by Respondent as an expert in this matter. His report and testimony were admitted into evidence as Respondent's Exhibits 1 and 2, respectively.

Dr. Jeffrey Soble is board-certified in Cardiology, Echo Cardiography and, Nuclear Cardiology. He wrote a six-page report dated July 6, 2020. It was admitted into evidence as Respondent's Exhibit No. 1.

Dr. Soble attempts to quantify the relationship between strenuous physical activity and heart attack as follows....

"...I cite what I believe to be the best study I can find on the subject, which basically looked at nearly 1200 patients who had a heart attack, and they documented the percentage of patients who had strenuous physical activity in temporal proximity to their heart attack compared to a matched population of similar patients who hadn't had a heart attack, and the excess number of patients with a heart attack related to strenuous activity was about 3% percent.

So it is very hard to quantify these things, these relatively minor effects, but that was my best attempt to quantify the degree to which, in general, strenuous physical activity might contribute to the incidence of heart attacks." (Deposition of Dr. Soble, pg 9)

Dr. Soble then goes on to explain the temporal relationship between physical activity and a heart attack as follows:

"Well, again, there is no standard for this, right? So there's no definition of when a heart attack is considered to be temporally related to strenuous activity.

You know, generally, we're talking about an association that's within an hour or two of the physical activity, that there's not a close -- you know, there's no absolute definition." (Deposition of Dr. Soble, pg 10)

Dr. Soble's understanding of the occurrences of January 21, 2013 is as follows:

"Well, my understanding was that, you know, he worked as a highway maintainer, basically working on -- with IDOT on the highways. It was winter, obviously."

"...he was doing roadwork after a storm and then began dealing with a snowplow that fell from a truck, had to be taken back to the yard, you know, I guess a loader, and reattached by a mechanic.

....And near mid-day, at about 11:30, he was in the yard and told one of his colleagues that he felt unwell, and that's when EMS was called, and he was taken pretty expeditiously to South Suburban."

"Well, I think you had to deal with the -- you know, he had to deal with the plow, which is undoubtedly a heavy piece of equipment; and he had to undoubtedly, you know, work with disconnecting the plow, potentially, you know, getting it onto a loader, getting it back to the yard; maybe helping the mechanic in the yard, I'm not sure, deal with the plow and trying to reattach it to the truck.

...I don't know to what degree--I don't know in detail what tools he had at his disposal, and, you know, I don't know at that level of detail."

"Well, I do remember one of his co-workers describing that he was struggling with the equipment at some point, so...

I don't remember the exact--I did read the description in the co-worker's statement, that, you know, he was struggling with some of the equipment in terms of--I'm not sure if it was disconnecting the plow or getting the plow onto the loader, but--" (Deposition of Dr. Soble, pgs 13-15)

Dr. Soble was not specifically aware of the physical position that Wallace was in when he was performing the strenuous activity.

"I'm not specifically aware. There might have been-- I assume he probably had to kneel down to deal with it, but I don't know for sure." (Deposition of Dr. Soble, pg 16)

With regard to the weight that Wallace was dealing with that day, Dr. Soble testified as follows:

"...I don't, you know, remember specifically what was described in the co-worker's report." (Deposition of Dr. Soble, pg 16)

With regard to the length of time that Wallace was engaged in this activity, Dr. Soble testified as follows:

"Well, I don't exactly know. I mean, the entire--you know, he was working this from 9:00 in the morning until—or, you know, maybe 9:30 in the morning until 11:30, so intermittently."
"I'm not sure how much time he was spending in that, you know, physical activity." (Deposition of Dr. Soble, pg 16-17)

Dr. Soble described the occupational risk factor for Wallace as follows:

"..And because it was my understanding that the occupational factors that were most at issue in this case were the strenuous occupational activity and exposure to the cold, I address those separately, as separate issues." (Deposition of Dr. Soble, pgs 19-20)

With regard to strenuous physical activity, Dr. Soble testifies as follows :

Q: ...And I note that you say in your report, and you conclude that 7.1 percent of patients had engaged in strenuous physical exertion at the time of the onset of MI compared to 3.9 percent of the mass controls, leading you to the conclusion in which you say that this suggests that strenuous physical exertion may account for approximately 3 percent of the risk.
Is that correct?

A: That's the best estimate I could come up with from the literature."
(Deposition of Dr. Soble, pgs 20-21)

Dr. Soble again reports increased risk as a result of strenuous physical exercise.

Q: ...So based upon the study that you used for the basis of your opinion in your report, which is dated July 6th of 2020, you conclude that the increased risk for the effect of the strenuous activity is 3.9 percent; is that--excuse me--3.1 percent; is that correct?

A: Something in that range. I mean these are just estimates."
(Deposition of Dr. Soble, pg 24)

Dr Soble quantified Wallace's risk with regard to severe weather as follows:

Q: ...You also looked at the weather as an occupational factor with regard to Mr. Wallace's MI; is that right?

A: Yep.

Q: And what assumption did you use with regard to what the weather was that day basing your opinion?

A: I think I used minus 11 degrees Celsius.
...I thought that might be the temperature that day.

Q: ...what did you conclude with regard to that analysis?

A: ...you know, overall, if you look at all the studies, and you look at kind of the overall effect that there could possibly be in terms of temperature on risk of heart attack, my conclusion from the literature is maybe you could tease out as much as an 8 percent overall increased risk of heart attack from the cold weather."
(Deposition of Dr. Soble, pgs 24-26)

In order to reach the conclusion with regard to temperature, Dr. Soble explained as follows:

Q: ...You told us in your report the average daily high temperature in Chicago, the daily high temperature during January is zero degrees centigrade; is that right?

A: Right.

Q: And using this temperature, you calculated the temperature at the time of the MI, of Mr. Wallace's MI, at minus 11 centigrade and then said that that converts to an 8 percent overall increased risk of heart attack for Mr. Wallace.

A: Yeah, that was the kind of quantitative estimate I could come up based on the data that was available in terms of changes--in temperature. (Deposition of Dr. Soble, pg 27)

Dr. Soble reiterates this opinion later on:

A: My point was if the average high temperature in January is zero and the temperature--approximate temperature at the time of his heart attack was minus 11, the best you might extrapolate from pooled data here, you know, to this specific case might be that that's about an 8 percent increase in MI (increased risk)"
(Deposition of Dr. Soble, pg 29)

Dr. Soble did not take into consideration the Petitioner's state of mind, i.e., the emergency situation that he was in at the time of his MI. The testimony is as follows:

Q: Doctor, I wanted to ask you about another factor that you did not comment on, and that is stressful situations....Do you have any opinion on this?

A: You know, that data does exist. I don't know how you--you know, most of it has to do with major life events, so--the problem with that is--you know, and I think that's real. So doing major life events people's health status overall, and potentially even their cardiovascular status, can be at higher risk.

...I have looked at this data in the past, and there's actually very little data that kind of day-to-day stress, even though stress is bad chronically, and—

Q: Yeah, but I'm not referring to that, doctor. I am referring to your first set of examples, you know, life-or-death or life-threatening situations.

...Those are the studies I am referring, which you do seem to be aware of.

...did you understand Mr. Wallace to be in any type of a life-threatening situation on the day of his heart attack, at the time of his heart attack?

A: I did not, actually, no.

Q: Okay. Would that change your opinion if you were to take into account that the workers involved in in this incident felt that it was a life-threatening situation for users of the highway?

A: I guess. I don't really know how you kind of quantify that or decide that. ...You know, these are people who have worked on highways in bad weather. So, you know, I guess my question is, how do they decide when a situation is more life threatening than another situation, you know?

Q: ...But you do suggest, Dr. Soble, that if that information were available to you, or if you were made aware of that type of information, that it may alter your opinion somewhat; is that correct?

A: Yeah. Well, I would certainly want my opinion to be informed by all the information possible.

You know, I only opined on the information I had available to me, that's for sure.
(Deposition of Dr. Soble, pgs. 31-34)

Dr. Soble comments on the position of an individual while performing strenuous activity.

Q: Doctor, are there any studies that you're aware of that indicate that a hunched-over position while performing strenuous activity is more dangerous than a straight-up position or a different position?

A: Well, I'm sure there are physiologic studies.

When you're hunched over, you know, and you're doing physical activity, your blood pressure could certainly go up from that position.
(Deposition of Dr. Soble, pg 36)

Dr. Soble believed that Mr. Wallace is only slightly more likely to have a heart attack because of occupational factors on January 21, 2013 and it is explained as follows:

Q: ...if Norman Wallace on January 21, 2013, which is the day he sustained a heart attack, were at home in a 72-degree apartment, or home, and was, let's say, playing a game of monopoly with his wife, can you say to a reasonable degree of medical and surgical certainty that he would have sustained a heart attack on that day?

A: I think it's, you know, just as likely he would have sustained a heart attack that day as on the day--you know, maybe slightly more likely in the way I've quantified it, based on the effects of strenuous activity and temperature. (Deposition of Dr. Soble, pg 38)

Dr. Soble was not aware that Wallace was out of breath immediately after performing strenuous activity.

Q: ...Did you understand him to be short of breath at any time that morning?

A: So from my reading of the--there wasn't a lot in the South Suburban notes, you know, in terms of history.

But from my reading of the co-worker's notes, you know, I think he just generally felt unwell.

I don't remember a lot of the specifics of which complaints he had at the time that he, you know, began feeling unwell and which ones he didn't have.
(Deposition of Dr. Soble, pg 42)

Dr. Soble did not consider the combination of the alleged occupational factors in attempting to quantify the occupational risk for Mr. Wallace.

Q: ...you have no opinion as to whether when those things occur together, i.e., strenuous activity in cold weather, whether you just add the two risk increases together or you multiply them or what, you don't have an opinion on that for us?

A: Well, I don't have an opinion from the literature, because I don't know of any data from the literature to cite."

Dr. Soble agreed that there was an increased risk of MI associated with strenuous physical activity. There is an increased risk of MI associated with cold weather conditions. There is an increased risk of MI associated with stressful situations.

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and the injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF DECEDENT'S EMPLOYMENT BY THE RESPONDENT, AND WITH RESPECT TO ISSUE (F), IS DECEDENT'S DEATH CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

The Arbitrator finds that Decedent, Norman Wallace sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 21, 2013 and that Decedent's death is causally related to his work accident.

Norman Wallace suffered a fatal MI on January 21, 2013. The evidence adduced shows that Wallace had personal risk factors for a MI, including: being a male (although Dr. Schneedberger did not endorse this as a risk factor); smoker; age 55; and obesity. Mr. Wallace's work activities for Respondent led to his fatal MI according to Dr. Schneedberger, whose opinions are found to be very persuasive and credible in this case. The extremely strenuous physical activity of hooking up the TMA, in the cold, windy and snowy weather conditions, and the difficult physical position that he had to be in to perform the job, along with the emotional stress of the dangerous conditions involving the plow/truck failure on I-57 increased the load on his heart and precipitated the MI and definitely played a role in accelerating the fatal MI. The MI is causally related to Wallace's work activities for Respondent on January 21, 2013.

Dr. Soble did not endorse causation and this opinion is not persuasive. He did not have a complete understanding of the nature of Wallace's work activities prior to the onset of the MI. He did concede that strenuous physical activity could be associated with a MI. He also conceded that cold weather and a hunched over posture could increase the risk of an MI.

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 **[***12]** his employment. *Baggett, 201Ill. 2d at 199; Paganelis v. Industrial Comm'n, 132 Ill. 2d 468, 480, 139 I. Dec. 477, 548 N.E. 2d 1033 (1989); Horath v. Industrial Comm'n, 96 Ill. 2d 349, 356, 70 Ill.Dec.741, 449 N.E. 2d 1345 (1983); Jones v. Industrial Comm'n, 93 Ill. 2d 524, 526, 67 Ill. Dec. 829, 445 N.E. 2d 309 (1983); Rogers v. Industrial Comm'n, 83 Ill.2d 221, 223, 46 Ill. Dec. 691, 414 N.E. 2d 744 (1980).* "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n, 167 Ill. 2d 77, 81, 212 Ill. Dec. 250, 656 N.E. 2d 1084 (1995); Scheffler Greenhouses, Inc. v. Industrial Comm'n, 66 Ill. 2d 361, 366, 5 Ill. Dec. 854, 362 N.E. 2d 325 (1977).* That is to say, for an injury to be compensable, it general must occur within the time and space boundaries of the employment. 1 A. Larson, Worker's Compensation Law § 12.01 (2002). It is not enough, however, to simply show that an injury occurred during working hours or at the place of employment. The injury **[***13]** must also "arise out of" the employment. *Parro v. Industrial Comm'n, 167 Ill. 2d 385, 393, 212 Ill. Dec. [***672] [****77] 537, 657 N.E. 2d 882 (1995)* (the occurrence of an accident at the claimant's workplace does not automatically establish that the injury arose out of the person's employment); *Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 62, 133 Ill. Ded. 454, 541 N.E. 2d 665 (1989).*

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 accident injury. *Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 62, 133 Ill. Ded. 454, 541 N.E. 2d 665 (1989).* **[*204]** Stated otherwise, "an injury arises out of one's employment if, at the time of the occurrence, the employee was

performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. [Citations.] A **[***14]** risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d at 58.* (*Sisbro v. Industrial Commission, 207 Ill. 2d 193, 797 NE2d 665 (2003)*)

The causation standard was well stated in *Sisbro v. Industrial Commission, 207 Ill. 2d 193, 797 NE2d 665 (2003)*, the Court opined as follows:

> "It is axiomatic that employers take their employees as they find them. *Baggett, 201Ill. 2d at 199.* "When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of **[***16]** and in the course of employment." *General Electric Co. v. Industrial Comm'n, 89 Ill. 2d 432, 60 Ill. Dec. 629, 433 N.E. 2nd 671 (1982).* Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery **[***673]** **[****78]** for an accident 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, 92 Ill. 2d at 36; Williams v. Industrial Comm'n, 85 Ill. 2d 117, 122, 51 Ill. Dec. 685, 421 N.E. 2d 193 (1981), County of Cook v. Industrial Comm'n, 69 Ill.2d 10, 18, 12 Ill.Dec 716, 370 N.E.2d 520 (1977); Town of Cicero v. Industrial Comm'n, 404 Ill. 487, 89 N.E. 2d 354 (1949)* (It is a well-settled rule that where an employee, in the performance of his duties and as a result thereof, is suddenly disabled, an accidental injury is sustained even though the result would not have obtained had the employee been in normal health). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition **[***17]** of ill-being. *Rock Road Construction Co. v. Industrial Comm'n, 37 Ill. 2d 123, 127, 227 N.E. 2d 65 (1967).*"

The overwhelming evidence in this case supports the Arbitrator's findings on the issues of accident/arising out of and in the course of and causation.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO DECEDENT 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 findings above, the Arbitrator awards the following medical expenses, which are found to be reasonable and necessary and causally related to the work accident:

- Bud's Ambulance Service $1,103.75 (Petitioner's Exhibit No. 3)
- Advocate Medical Group $3,438.00 (Petitioner's Exhibit No. 4A)

- Advocate South Suburban Hosp. $27,042.00 (Petitioner's Exhibit No. 4B)

TOTAL: **$31,583.75**

WITH RESPECT TO ISSUE (O), DEATH BENEFITS, THE ARBITRATOR FINDS:

Based upon the Arbitrator's findings above, Respondent shall pay death benefits, commencing January 22, 2013, of $1,019.59 per week to the surviving spouse, Sharon Wallace, until $500,000 has been paid or 25 years, whichever is greater, have been paid, because the injury caused Norman Wallace's death, as provided in Section 7 of the Act.

If the surviving spouse remarries, Respondent shall pay the surviving spouse a lump sum equal to two years of compensation benefits; all further rights of the surviving spouse shall be extinguished.

Respondent shall pay $8,000 for burial expenses to the surviving spouse, as provided in Section 7(f) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC035453
Case Name	KELLY, DILLON v. ILLINOIS YOUTH CENTER KEWANEE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0395
Number of Pages of Decision	11
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Karin Connelly
Respondent Attorney	Brett Kolditz

DATE FILED: 8/4/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dillon Kelly,

Petitioner,

vs. NO. 15WC35453

Illinois Youth Center Kewanee,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2017 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

August 4, 2021

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

SJM/sj
o-7/13/2021
44

/s/ *Deborah Simpson*
Deborah Simpson

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0395

KELLY, DILLON
Employee/Petitioner

Case# **15WC035453**

ILLINOIS YOUTH CENTER KEWANEE
Employer/Respondent

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

If the Commission reviews this award, interest of 1.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
KARIN K CONNELLY
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

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

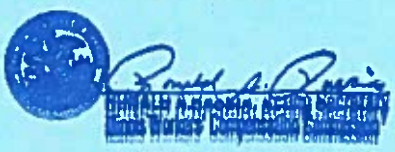
5300 ASSISTANT ATTORNEY GENERAL
CODY KAY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

DEC 18 2017



STATE OF ILLINOIS)
)SS.
COUNTY OF **Rock Island**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dillon Kelly
Employee/Petitioner

v.

Illinois Youth Center Kewanee
Employer/Respondent

Case # **15** WC **35453**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **February 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/5/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,001.00**; the average weekly wage was **$1,086.49**.

On the date of accident, Petitioner was **24** years of age, *single* with **no** dependent children.

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

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

Respondent shall be given a credit of **$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

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$651.89**/week for **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **5% loss of the left leg.**

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

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

Michael K. Nowak, Arbitrator

11/28/17
Date

ICArbDec p. 2

DEC 12 2017

FINDINGS OF FACT

Dillion Kelly worked for the Illinois Youth Center at Kewanee for 1 year prior to his accident on September 5, 2015. He worked as a youth specialist or prison guard and it was his job to both supervise and protect the inmates. On September 5, 2015, he was working with an unruly youth and was manning the youth's arms, attempting to remove his wrist restraints. The youth in question grabbed him by the leg and tried to break his leg by hitting it against a door frame. Mr. Kelly was able to extricate himself from this assault and eventually exit the jail cell. He was able to extricate himself from the assault by shaking his leg. The youth in question was approximately 6'3, 240 pounds and was described as being "strong".

Immediately following the assault Mr. Kelly notified his supervisor and noted his left leg (knee) hurt a lot, was bruised and his knee was swollen. Mr. Dillon saw the nurse, who is located at the correctional facility and was referred to the emergency room. At St. Luke's emergency room in Kewanee he underwent an MRI, was diagnosed with a sprain and contusion and was prescribed the use of crutches. At the time, Mr. Kelly went to the emergency room his leg was swollen, the inside had turned black and blue and he was not able to be weight bearing. He was also prescribed pain medication and instructed to see his personal physician.

Dr. Mols , the petitioner's family physician, saw the petitioner and restricted him from working. She also referred him to physical therapy.

During the time that petitioner was in physical therapy he noticed that the condition of his left knee was better but he also noted weakness and it was hard to use. He was assigned to light duty working in a "pod" office where he did not have contact with inmates.

Currently, the petitioner notices swelling and aching in his left knee when he exercises or performs strenuous activities. He notices these symptoms both on the inside and outside of the knee, takes Aleve, and uses ice and rest in order to alleviate these symptoms. This occurs 1 to 2 times per week.

The facility at which he was working at the time of the injury is currently closed as a youth prison and is reopening as an adult correctional facility. He is working moving things and readying the facility for the inmates and will continue working there with adult prisoners. He notices the above symptoms occur while performing his job activates. The petitioner has not gone back to his physician with respect to this injury since his release because he knows that, pursuant to the MRI, nothing is torn in his knee. He assumes that ice and Aleve is what the doctor will prescribe to him so he did not see a reason to go back to the doctor.

The petitioner testified that he needs to stay in shape because he works with inmates and "stuff goes wrong". He does not want the inmate to have the upper hand and believes that staying fit is a safety issue. He intends to continue his career with the Illinois Department of Corrections.

On cross examination, the petitioner was asked about Dr. Mols last treatment note which indicted that his pain was gone and he did not have weakness, numbness or tingling. Mr. Kelly agreed that at the time he was released from Dr. Mols he was not experiencing symptoms. He additionally testified that he had not returned to his regular job and had not resumed his exercise routine when released from the doctor. When he went back to his regular position he again experienced the symptoms he described at the hearing.

CONCLUSIONS

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

The Arbitrator finds that the petitioners current condition of his left leg is causally related to the injury he suffered September 5, 2015. The petitioner creditably testified to being the victim of an assault by an inmate at the Illinois Youth Center (Kewanee). In that assault, a youth prisoner initiated an altercation in which he tried to break the petitioner's left leg by hitting it against a door frame. Mr. Kelly was able to extricate himself from the confrontation, however, noted an injury to his left knee immediately thereafter.

The petitioner received immediate medical treatment from the nurse at the correctional facility and was referred to the emergency room. While the MRI taken at the emergency room did not indicate any tears in the left knee Mr. Kelly was diagnosed with a sprain/ strain/ contusion injury, was prescribed medication, was restricted from weight bearing and was referred to his family physician for further treatment.

Dr. Mols, the petitioner's family physician, concurred in the diagnoses from the emergency room, restricted the petitioner from weight bearing and work activities and referred him to physical therapy. The petitioner concluded treatment, was released to regular duty and was also released from care by his physician. He creditably testified to continue symptoms following the resumption of his regular duty work and the exercise program he performs, at least in part, to keep him prepared to perform his job-related duties as a correctional officer in the Illinois department of corrections. He has not suffered any additional injury to his left knee following the accident in question and reasonably testified that he has not returned to see his doctor as he knows he does not have anything torn in his knee and feels that he would be prescribed ice, rest and Aleve, a treatment path he is pursuing on his own.

The arbitrator finds that the current condition of the petitioners left knee is casually related to the accident of September 5, 2015.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes the petitioner was employed as a correctional officer at the Illinois youth center in Kewanee at the time of his injury. That facility is currently in the process of being converted to an adult correctional facility and the petitioner testified that he will continue to work in his capacity as a correctional officer at that facility. The petitioner further testified that he feels it is important to remain physically fit while working as a correctional officer in

order that a safe environment exists for both the prisoners and the correctional officers. He notices swelling and pain in his left knee when he performs the exercises necessary to maintain a fitness level to appropriately perform his job activities. The fact that the petitioner needs to maintain a level of physical fitness is evident when examining the nature of the injury he suffered on September 5, 2015 and the need to extricate himself from a situation in which he was attacked by a violent inmate who attempted to break his leg. The petitioner's occupation has a significant impact on the permanent disability that he suffered as a result of said accident. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that at the time of the injury the petitioner was 24 years of age. He testified that he intends to continue throughout his career working as a correctional officer for the State of Illinois. Mr. Kelly will have many years during which he will have to work with his knee that was injured in the September 5, 2015 accident. He indicates that it continues to bother him during his work activities and when he exercises. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b). Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The petitioner, Mr. Kelly, described ongoing complaints with respect to his left leg. They occur when he exercises and performs strenuous activities, including work activities. He testified to pain and swelling that occurs on both sides of his knee. This testimony is corroborated by the medical records both of Dr. Mols and the physical therapy. The diagnoses of a sprain/strain/contusion are consistent with and located in the same area were Mr. Kelly continues to complain of pain.

Further, Mr. Kelly's testimony, that he was not experiencing symptoms of at the time he was released from Dr. Mols care is both reasonable and credible. He was performing light duty work and not participating in strenuous work activity or exercise activities, which he indicates exacerbate his symptoms. His testimony that he has not returned to see Dr. Mols is also reasonable under the circumstances. He is aware that he did not suffer any torn ligaments or tendons in the accident and is treating his symptoms with rest, ice and Aleve. The Arbitrator therefore gives *some* weight to this factor.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC019513
Case Name	RITZ III, STEPHEN v. ALPHA SCHOOL BUS COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0396
Number of Pages of Decision	19
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Randall Sladek
Respondent Attorney	Bonnie B. Bijak

DATE FILED: 8/4/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Ritz III,

Petitioner,

vs. NO. 17WC 19513

Alpha School Bus 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 issue(s) of accident, medical expenses, causal connection, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 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.

August 4, 2021

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

SJM/sj
o-6/22/2021
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/s/ *Deborah Simpson*
Deborah Simpson

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RITZ III, STEPHEN
Employee/Petitioner

Case# **17WC019513**

ALPHA SCHOOL BUS COMPANY
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:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

1739 STONE & JOHNSON CHARTERED
BONNIE B BIJAK
111 W WASHINGTON ST SUITE 1800
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

Stephen Ritz III
Employee/Petitioner

v.

Alpha School Bus Company
Employer/Respondent

Case # **17** WC **19513**

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 McLaughlin**, Arbitrator of the Commission, in the city of **Chicago**, on **10/1/20**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

O. ☐ Other _____

FINDINGS

On **6/21/17**, 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 $**6,452.82**; the average weekly wage was $**169.81**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** 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 $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $294,925.70, as provided in Section 8(a) of the Act. Respondent shall pay these charges pursuant to the medical fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $169.81/week for 70 1/7 weeks of compensation, commencing 6/22/17 through 10/25/18, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of 87.5 weeks of compensation, based on the Arbitrator's finding that the injuries sustained caused the Petitioner 17.5% 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

Date

JAN - 8 2021

FINDINGS OF FACTS

At the time of the alleged accident June 21, 2017, the Petitioner, Stephen Ritz III was a 49-year-old married man with two dependents under the age of 18. On June 21, 2017, Petitioner was employed as a part time shuttle bus driver for Midway Shuttle. (Group Ex. 1). The Petitioner testified that he had worked as a part time bus driver with Alpha School Bus since 2012, and worked approximately twenty hours every two weeks, or two hours a day. (TX P 10) His job was to drive special needs children. (TX P 11) Prior to driving his bus route each day, the Petitioner testified that he was responsible for checking the bus, walking around making sure everything was operating, checking the lights, windshields, horn, back door and making sure all exits were operating and the blinkers working. (TX P 11)

The Petitioner testified that on the morning of the incident, he "fell" when he went to open a window and tripped over the sure-Lok which was used to tie down the wheelchairs. (TX. P 12) When Petitioner fell; he could not get up because he was in pain. Because petitioner was alone on the bus, he called dispatch from his cellular phone. (TX P 12) The Petitioner testified that the pain was in his lower back. (TX P13) He stated that dispatch called an ambulance and the ambulance transported him to Metro South Hospital emergency room. (TX P13; TX 32)

When the Crestwood Fire Department arrived at the Alpha Bus Company, they reported that they found the Petitioner alert, oriented x 3 and stable. (TX P33; RX Ex 2, P 43) Petitioner reported to the ambulance driver that he was attempting to "open a window inside the bus and while reaching he lost his balance and fell to his back. (TX 33; RX EX 43) The Petitioner testified that the paramedics carried him off the bus. (TX P 39; Rx Ex 4 P 1)

The Petitioner testified that when he got to the hospital, he had shooting pains down his leg, back pain and his neck hurt. (TX P 14) In triage at the Emergency room, the patient advised them that he was working on his bus when he slipped and fell. (RX. Ex 2, P11) He further advised them that he heard a pop and he was complaining of numbness and tingling in his left lower extremity. (RX. Ex. 2, P 11)

At the hospital a CT of the brain, showed no acute intracranial process. (RX. Ex 2, PP 13-14, PP 53-54) A CT of the cervical spine showed no acute fracture or traumatic misalignment. (RX. EX 2, PP 14-15, PP 52-53) A CT of the left lower back showed degenerative changes of the lumbar spine without acute fractural, advanced L5-S1 neural foraminal narrowing and moderate lateral recess, and multilevel of mild to moderate central canal stenosis. (RX. Ex 2, PP 15-16, P 51) An MRI of the thoracic spine showed spondylotic changes and facet arthrosis, with no acute findings of fracture or listhesis. (RX. Ex 2)

Petitioner was advised to follow up with his regular family physician. (TX 35) The principal discharge diagnosis was low back pain and the secondary diagnoses was anesthesia of skin, fall on same level from slipping, tripping, hypertension, type 2 diabetes with chronic hypertensive kidney disease. (RX Ex 2, P 5)

The petitioner testified that he was referred to Dr. Darwish, who he saw on June 28, 2017, a week after the alleged incident. (TX P 15) Petitioner advised Dr. Darwish that he stepped on to the bus and tripped over the wheel locks – "sure locks, the tie down to the wheelchair". (TX P 36) Dr. Darwish examined his neck and low back, and referred him to Dr. Malhotra, a pain doctor, who performed a lumbar injection on July 26, 2017. (TX PP 16-17)

The Petitioner went to see Dr. Wehner on August 7, 2017. (TX P 18 TX P 39) The Petitioner recalled telling Dr. Wehner that he was opening a window on the bus, when he fell. (TX PP 39-40)

The Petitioner testified that he continued to see Dr. Darwish, who recommended an interbody fusion at L5-S1. (TX PP (18-19)

The Petitioner testified that Dr. Darwish performed surgery on his lower back on December 6, 2017, and a month after the surgery he felt weak and pain. (TX P 22) When he saw Dr. Darwish on December 22, 2017, he was having issues with other body parts including his neck, back and left foot numbness. Dr. Darwish referred him to get a brace so he would not drag his foot. (TX PP 22-23) He continued to see Dr. Darwish every other month after the surgery and PT was recommended. (TX P 24)

The Petitioner's brace was viewed during the hearing and was described as being from the boot until 6-7 inches from his knee. (TX P 24)

On March 8, 2018 the Petitioner saw Dr. Darwish and was ambulating with a cane. (TX P 24-25) When the Petitioner saw Dr. Darwish on September 13, 2018 he had pain every other day, sometimes twice a day, and he was on hydrocodone and muscle relaxers. (TX P 27) Dr. Darwish recommended an FCE, which was done on October 8, 2018. (TX P 28) Dr. Darwish released him to return to work on October 25, 2018, although the Petitioner was still on medications, including cyclobenzaprine, Nalfon, Gabapentin, Lidoderm patches and Norco. (TX PP 28-29)

After the Petitioner was released by Dr. Darwish he continued to see Dr. Malhotra for pain management, and Dr. Malhotra continues to provide him prescriptions. (TX P 30) The petitioner testified that he took hydrocodone and cytasbetrapleene on the morning of the hearing. (TX P 29)

The Petitioner testified that he has not returned to work, and when he called Alpha Bus Company "they did not want to talk to him". (TX PX 31-32) He continues to have pain in his lower back. (TX P32)

Mr. Linon Glenn III, the operations manager of Alpha Bus Company was called to testify, as the operations manager. (TX P 50) He testified that he was advised that Steven tripped over one of the tie downs for the wheelchair restraint and fell on his knee. (TX P 51) Mr. Glenn testified that the drivers pick their routes by seniority, and were aware of how when the routes would start and finish. (TX P 53) He never personally talked to Mr. Ritz about what occurred on the date of the incident, and did not recall Mr. Ritz ever contacting him about returning to work. (TX. P 54)

Dr. Wehner requested additional records from the nurse case manager in order to establish a base line for the Petitioner's pre-existing condition. (RX. EX 7, PP 17-18) Dr. Wehner was provided additional medical records and documents and generated an addendum report, dated June 20, 2019, (RX. Ex 7, RX. EX 7, ex 3 dated 9-10-19) After review of the records, Dr. Wehner further opined that the Petitioner's ten-day hospital stay following his December 6, 2017 procedure, was at least two to three times longer than the average stay for the type of surgery that Dr. Darwish performed. (RX Ex

7, PP 23-24; Rx Ex 7, ex 3 dated 9-10-19) Dr. Wehner further opined that the petitioner did not sustain any new injury to the L5-S1 area following the June 2017 trip and fall. (RX Ex 7, PP 26-27; ex 3, dated 9-10-19)

CONCLUSIONS OF LAW

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

Section 1(b) 3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b) 3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim *(O'Dette v. Industrial Commission*, 79 Ill. 2d 249,253 (1980)), including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Disputed 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, a claimant bears the burden of showing by a preponderance of the evidence, that the claimant 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, 8-797 N.E.2d 665, 671 (2003). In the course of employment refers to the time, place and circumstances surrounding the injury and, generally, must occur within the time and space boundaries of the employment. *Id*. An injury "arises out of" employment when "the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id* at 203, 797 N.E.2d at 672.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the credible evidence that Petitioner suffered an injury that arose out of and the in the course of his employment by Respondent on June 21, 2017.

Arbitrator finds Petitioner's testimony credible as to the events that occurred on the June 21, 2017. It is undisputed that Petitioner was found lying on the floor of the bus. The Petitioner's unrebutted testimony as to what occurred combined with the Respondent's witness, Mr. Glenn, who confirmed that there are Sure-loks protruding from the bus floor, as well as the Section 12 examiner, Dr. Wehner, who confirmed the Petitioner suffered a lumbar contusion, leads the Arbitrator to conclude that the Petitioner met his burden in proving that the accident occurred during his employment on June 21, 2017.

Disputed Issue (F): Whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52,133 Ill.Dec. 454, 541 N.E.2d 665 (1989). 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 if it can be shown that the employment was a causative factor. *Id.*

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the credible evidence that her current condition of ill-being is causally related to his work accident of June 21, 2017.

The Petitioner testified that he fell in a bus when he went to open a window and tripped on a Sure-Lok. (Tx p. 12) After his fall, an ambulance was dispatched, arrived, and transported him to the Emergency Room. (Tx p.13; Tx p. 30)

Petitioner was mainly treated by Dr. Darwish and eventually had surgery to treat his injuries.

The Arbitrator did consider the opinion of the section 12 examiner, Dr. Wehner, that Petitioner did not sustain a new injury on his L5-Sd1 area, however the Arbitrator finds that Dr. Wehner's opinion was formed prior to Dr. Wehner having reviewed all of Petitioner's prior medical records.

Therefore, Arbitrator gives greater weight to Petitioner's treating doctor, Dr. Darwish than the opinion of Dr. Wehner. When considering Petitionr's prior injury the Arbitrator also considered and gave great weight to the fact that Petitioner was released to full duty in December 2010, by his prior doctor after his injury in 2007.

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

The Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence entitlement to payment of the sustained injuries. The Arbitrator notes Respondent offered no medical evidence to dispute payment other than Dr. Wehner opined that the Petitioner's hospital stay was longer than should have been. Based on the foregoing, petitioner's treatment was reasonable and necessary to address his lumbar spine issues resulting from the work accident. Accordingly, the Arbitrator awards medicals bills as follows, per the medical fee schedule:

Hinsdale Orthpedics (Px. 1)	$69,334.00
MetroSouth Hospital (Px. 2)	$18,206.12
ATI (Px. 3)	$39,659.02
Expert Pain Physicians (Px. 4)	$5,010.00

Injured Workers Pharmacy (Px. 5)	$26,905.07
Hinsdale Hospital (Px. 7)	$133,041.95
Scheck and Sirees Prosthetics (Px. 8)	$847.00
Therapeutic Pain Services (Px. 9)	$1,702.44
UroPartners (Px. 10)	$220.10

Disputed issue (K): WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE, IF ANY, THE ARBITRATOR FINDS AS FOLLOWS:

To be entitled to receive TTD the claimant must show not only that he or she did not work but also that he was unable to work. *Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 923 N.E.2d 266, 337 Ill.Dec. 707 (2010). Petitioner claims to be entitled to temporary total disability benefits from June 22, 2000 through his discharge by Dr. Darwish on October 25, 2018, Petitioner testified that Dr. Darwish limited his lifting ability whereby he was unable to work until his full release on October 25, 2018. (T P 27)

Arbitrator gives weight to the credible testimony that he attempted to contact the company in regards to work and received no response back. Arbitrator finds that Dr. Darwish's opinion as credible as to whether Petitioner was able to work during the period at issue.

The Arbitrator awards the Petitioner Temporary Total Disability for 70 1/7 weeks of compensation at a rate of $169.81.

Disputed issue (L): What is the nature and extent of the injury?

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall 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.

The Petitioner sustained injury to his lumbar spine which required L5-S1 transforaminal lumbar interbody fusion with posterior instrumentation and the use of allograft bone. He was able to return to his pre-injury physical and work baseline.

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 bus driver at the time of

the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes petitioner returned to his physical baseline following the injury and recovery. The Arbitrator therefore gives moderate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. Because of another 15-20 years anticipated part time work, the Arbitrator therefore gives moderate weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes petitioner was working part time at a modest wage. Because of his ability to return to that level of work, the Arbitrator therefore gives lesser 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 a functional capacity evaluation verified petitioner could return to bus driving although with significant restrictions. Because of a relatively limited labor market following the injury, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17.5% loss of use of the person as a whole, pursuant to §8(e) of the Act. (87.5 weeks of compensation).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC011040
Case Name	RIVERA, PEDRO URTADO v. FLEXIBLE STAFFING SERVICE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0397
Number of Pages of Decision	13
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Jacob Schneider

DATE FILED: 8/4/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pedro Urtado Rivera,

Petitioner,

vs. NO. 19WC11040

Flexible Staffing Service,

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(s) of accident, medical expenses, causal connection, 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 28, 2020 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,700.00. 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.

August 4, 2021

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

SJM/sj
o-6/22/2021
44

/s/ *Deborah Simpson*
Deborah Simpson

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0397
NOTICE OF 19(b) ARBITRATOR DECISION

RIVERA, PEDRO URTADO Case# **19WC011040**

Employee/Petitioner

FLEXIBLE STAFFING SERVICE

Employer/Respondent

On 10/28/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2553 McHARGUE & JONES LLC
BRENTON M SCHMITZ
12 W MADISON ST 18TH FL
CHICAGO, IL 60602

3998 ROSARIO CIBELLA & ASSOC LTD
JACOB SCHNEIDER
2561 DIVISION ST SUITE 103
JOLIET, IL 60435

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)

PEDRO RIVERA URTADO
Employee/Petitioner

v.

FLEXIBLE STAFFING SERVICES
Employer/Respondent

Case # **19** WC **11040**

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 **7/22/2020**. 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, **2/18/2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**N/A**; the average weekly wage was $**483.75**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

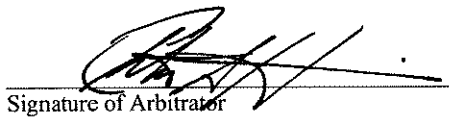
The Arbitrator finds that Petitioner's current condition of ill-being relative to his right foot is causally connected to the work accident dated February 18, 2019. The Arbitrator further finds that Petitioner was at MMI as of July 29, 2020 – the date of his full release by his treating physician.

Respondent shall pay the following reasonable and necessary medical services, pursuant to the medical fee schedule or other lesser negotiated amount: $1,207.77 to Illinois Orthopedic Network, $277.32 to Midwest Specialty Pharmacy, and $4,500.00 to Preferred Open MRI, as provided in Sections 8(a) and 8.2 of the Act.

Based on the factors as enumerated in the Arbitrator's Conclusions of Law which accompany this Order, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the right foot pursuant to §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

10/26/2020
Date

OCT 28 2020

FINDINGS OF FACT

On February 18, 2019, Petitioner Pedro Rivera Urtado ("Petitioner") was an employee of temporary staffing agency Flexible Staffing Services ("Respondent"). (Transcript of Proceedings ("Trans.") dated July 22, 2020 at 9). He was assigned by Respondent to work at Ideal, a company which fabricates cardboard boxes. (Id. 10). His job duties included stacking boxes and assisting a machine operator. (Trans. at 11). On February 18, 2019, Petitioner was solo operating a machine which normally required two people to operate. (Id.). Operating this machine physically required Petitioner to make backwards movements. (Id.). During one of these steps backwards, Petitioner's right foot became entangled with cables and pedals on the floor, and he fell backwards. (Id. at 11-12). With his right foot still entangled, Petitioner fell to the ground, impacting his back and right foot. (Id. at 12). Petitioner testified that he felt immediate pain and inflammation in his right foot. (Id.).

Petitioner filed a report with the human resources office and finished that last few hours of his shift. (Id. at 13). Petitioner returned to work the next day on February 19th and testified that his right foot around the ankle continued to "feel bad". (Id. at 14). The next day, February 20th, Petitioner was sent by the Respondent to Concentra Medical Center ("Concentra"). (Id. at 14-15). Petitioner was seen by Dr. Homer Diadula ("Dr. Diadula") and presented with a right heel injury with 5/10 pain in the right Achilles tendon and distal portion of its insertion to the heel. (Pet. Ex. 1 at 1). An x-ray revealed no fracture. (Id. at 2). Dr. Diadula assessed Petitioner as having a strain of the Achilles tendon and released him to full work duty. (Id.). Petitioner returned to Dr. Diadula for a second recheck on February 22nd and was determined to be in the same condition as his first visit, but this time was referred to physical therapy. (Id. at 7).

Petitioner returned to Dr. Diadula a third time on February 28th. (Id. at 10). Dr. Diadula ordered an MRI of the right ankle, and imposed restrictions on Petitioner – no walking or climbing on uneven terrain, and that Petitioner should be sitting 90% of the time. (Id. at 10-13). The MRI was performed on March 20, 2019 and reviewed by Dr. Eugene Pai ("Dr. Pai"). (Pet. Ex. 2 at 2-3). The impressions from this MRI indicated a peroneus brevis tendon thinned from partial-tear, lateral collateral ligament sprain with interstitial partial-tear CFL & ATFL, Achilles thickening from chronic tendinopathy with associated minimal retrocalcaneal bursitis, and plantar fascia thickening from chronic plantar fasciitis. (Id. at 3). Dr. Diadula reviewed the MRI with Petitioner on March 26, 2019 and concluded that there was a right ankle tendon tear, retrocalcaneal bursitis, plantar fasciitis, and a strain of the Achilles tendon. (Pet. Ex. 1 at 16). He further referred Petitioner for an orthopedic consult. (Id.). During this period, Petitioner testified that he engaged in physical therapy exercises which he found to be unhelpful. (Trans. at 16).

Petitioner followed up with Dr. Kevin Tu ("Dr. Tu") of Concentra on April 3, 2019 for his orthopedic consultation. (Pet. Ex. 1 at 22). Dr. Tu's examination revealed full range of motion and tenderness with palpation over the Achilles tendon and medially over the posterior tibialis tendon, but otherwise with no tenderness medially over the posterior tibialis tendon and no laxity of the joint. (Id.) Dr. Tu diagnosed Petitioner with right ankle Achilles tendinopathy and posterior tibialis tendinitis, maintained similar restrictions to those issued by Dr. Diadula, and referred Petitioner to a foot and ankle specialist. (Id.). Petitioner did not follow-up with the recommended specialist, surgeon, or any other treating physician until March 2020 – nearly one year later. (Trans. at 16-17, 24-25).

On May 17, 2019, Petitioner appeared for a Section 12 IME examination with orthopedic surgeon Dr. Anand Vora ("Dr. Vora"). (Resp. Ex. 1 at 1). Petitioner described ongoing posterior

ankle pain and Achilles issues, and that he had returned to work but had been primarily working from a sedentary position per his prior work restrictions. (Id. at 2). Dr. Vora conducted a physical examination in which he found that Petitioner had no obvious deformity, with full range of motion and strength. (Id.). He noted that there was subjective pain reproduced with palpation along the course of the posterior tibial tendon, but strength and function were intact. (Id.). X-ray views were obtained which showed no evidence of fracture or abnormality. (Id.). Dr. Vora noted that he did not have the previously taken MRI films or report to review. (Id.). He believed treatment to date had been reasonable and necessary, but indicated he needed to review the MRI films in order to determine whether Petitioner was at MMI and could return to full work duty without restrictions. (Id. at 2-4).

Upon receipt of the March 20, 2019 MRI report, but without complete readable MRI images, Dr. Vora completed his first addendum report on May 29, 2019. (Resp. Ex. 2). Dr. Vora acknowledged the that the MRI report suggested evidence of peroneus brevis tendon partial tear, lateral collateral ligament sprain, Achilles thickening with chronic tendinopathy with minimal retrocalcaneal bursitis and plantar fasciitis. (Id.). However, Dr. Vora opined that the MRI report indicated chronic changes of the Achilles tendon which were inconsistent with any acute pathology. (Id.) In particular, the findings of the lateral ankle of the peroneal tendon and lateral ankle ligament complex did not correspond with the location of pain and Petitioner's symptoms. (Id.). As a result, Dr. Vora believed Petitioner's condition was chronic rather than acute, and that it did not result from a work injury. (Id.). Dr. Vora did not offer an opinion as to whether Petitioner's alleged work injury aggravated a pre-existing condition. (Id.).

A second addendum report was generated on September 16, 2019, in which Dr. Vora reviewed the actual MRI images from March 20, 2019[1], which had previously been unreadable. (Resp. Ex. 3). Dr. Vora found that the ATFL and CFL tears where chronic in nature, and that the findings and images were unrelated to the location of symptomology as documented in the treater's medical records and previous IME examination. (Id.). Dr. Vora concluded that Petitioner could return to regular work duty without restrictions. (Id.).

Petitioner testified that he continued sedentary work with Respondent through March 2020. (Trans. at 17). During this period, Petitioner had received no further medical treatment and testified that during this period his foot was feeling better. (Id. at 17-18).

Petitioner then wanted to see another doctor, and on March 9, 2020, Petitioner met with Dr. Eugene Lipov ("Dr. Lipov"). (Pet. Ex. 2 at 5). Dr. Lipov received a consistent work history, continued the previous light duty restrictions and recommended a new MRI be taken. (Id.). Dr. Lipov agreed that the March 20, 2019 MRI did show a partial tear of the CFL and ATFL as well as a lateral collateral ligament sprain and thinning of the peroneus brevis, along with chronic tendinopathy. (Id.). Dr. Lipov recommended a repeat right ankle MRI to determine if the previously visible partial tears had healed in the intervening months since Petitioner's last follow-up with Dr. Tu and referred Petitioner to Dr. Joel Anderson ("Dr. Anderson") – a Doctor of Podiatric Medicine. (Id.).

Petitioner underwent a second MRI of the right ankle on March 14, 2020, in which Dr. Eugene Pai identified Achilles thickening and signal abnormality from non-specific tendinosis and plantar fasciitis – findings which had been present on the first MRI. (Pet. Ex. 2 at 8-9). The CFL and ATFL partial tears, as well as the peroneus brevis partial tear were absent from this MRI. (Id. at 9). After reviewing the 2nd MRI report, Dr. Anderson recommended that another stronger MRI be taken with a 3.0 Tesla machine similar to the first MRI. (Id. at 11).

[1] In his report, Dr. Vora erroneously refers to a May 20, 2019 MRI images instead of March 20, 2019 images.

The third MRI was completed on April 21, 2020. (Id. at 16). This MRI revealed findings compatible with a "likely grade 1 sprain of the ATFL" but noted that it could also be a consistent chronic low-grade sprain, as well as a small subcortical cyst along the posterior calcaneal tubercle. (Pet. Ex. 2 at 14-16). The MRI report also noted that the remainder of the lateral collateral ligaments of the ankle appeared intact, the peroneal tendons of the lateral right ankle appeared longitudinally intact and unremarkable, and that the right Achilles tendon was also intact – with no tears or insertional tendinopathy evident. (Id. at 16).

On May 27, 2020, Dr. Anderson reviewed the report from the April 21st MRI, noting the same findings as the radiologist. (Id. at 20.). He further noted that the images on the MRI would be consistent with a peroneus brevis tendon partial tear but noted that Petitioner's current symptomatology seemed to be more consistent with a posterior impingement of the OS Trigonum and sinus tarsi syndrome. (Id.). As a result of this finding Dr. Anderson recommended a fourth MRI be performed. (Id.). Dr. Anderson also administered a cortisone injection at the sinus tarsi, based on his diagnosis of possible sinus tarsi syndrome. (Id. at 23). Petitioner testified that this injection was not helpful. (Trans. at 18). At a follow-up visit on June 10, 2020, Dr. Anderson noted continued pain at the lateral ankle, sinus tarsi, and medial ankle and repeated his recommendation for a fourth MRI. (Pet. Ex. 2 at 27).

The fourth MRI was completed on June 12, 2020 and revealed no tears of the peroneal tendon. (Id. at 29-31). Dr. Anderson reviewed these MRI results on June 29, 2020 and noted the lack of any identifiable pathology – both peroneal tendons were intact with no interstitial signal changes or tendinopathy. (Id.). Dr. Anderson asserted that Petitioner may need further workup by a rheumatologist for general foot joint pain to rule out an underlying systemic condition, but that such a workup for Petitioner's asserted manifestation of pain would not be related to the work injury suffered by Petitioner. (Id. at 34-35). Dr. Anderson discharged Petitioner from his care at full duty as of June 29, 2020. (Id. at 35).

Petitioner testified at trial that his foot does not feel normal and that it bothers him and swells when he walks. (Trans. at 19). When he climbs stairs, it also does not feel normal. (Id. at 19-20). Petitioner testified that prior to the work injury, he did not have any other accidents or injuries involving his right foot. (Id. at 20). Petitioner stated that he would like an opportunity to obtain a definitive diagnosis from another physician. (Id.).

CONCLUSIONS OF LAW

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

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

Petitioner credibly testified that on February 18, 2019, while working for the Respondent, he tripped over cables while operating machinery at his workstation and fell to the ground. (Id. at 11-12). He credibly testified that he felt immediate pain and inflammation in the right foot. (Id. at 13). Petitioner was seen at Concentra two days later and gave a consistent history of the accident – and continued to do so to all subsequent providers. (Id. at 14-15). The Arbitrator finds Petitioner's testimony to be both credible and unrebutted and further finds that Petitioner's injury arose out of and occurred in the course of his employment with Respondent.

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

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

After hearing the testimony of Petitioner and reviewing the medical records, the Arbitrator finds Petitioner's current condition of ill-being was causally related to the accident of February 18, 2020 through the full release date of June 29, 2020 at which time the Arbitrator finds that Petitioner was at MMI.

Based upon review of the records and testimony, the Arbitrator finds Petitioner suffered a partial tear of the peroneus brevis tendon, a partial tear of the ATFL and CFL, and a strain of the Achilles tendon with accompanying tendinopathy - all located in Petitioner's right foot. The Arbitrator finds that the records of Doctors Diadula, Lipov and Anderson are persuasive in determining the extent of Petitioner's injuries and their resolution after conservative care. Their findings are supported by the various MRI's taken of Petitioner's right foot and establish that the injuries suffered healed or otherwise diminished in the time between the date of injury and the MMI date of June 29, 2020.

The medical records and testimony submitted into evidence reflect that Petitioner continues to feel pain in his right ankle, but in locations which were unrelated to the sites of injury revealed in the four MRIs and reported to the various physicians. Dr. Anderson acknowledged that any of the current pain exhibited by Petitioner was unrelated to the February 18, 2019 injury. (Res. Ex. 2 at 34).

J. Were the medical services 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) and (C) as set forth fully herein.

At trial, Petitioner presented additional medical billing records related to unstipulated injuries discussed *supra*. Upon review, these medical records are causally related to the February 18, 2019 work injury. The Arbitrator therefore finds Respondent responsible for payment of the following additional medical bills pursuant to the fee schedule or as otherwise negotiated:

1. Illinois Orthopedic Network (Pet. Ex. 2 at 1)	$1,207.77
2. Midwest Specialty Pharmacy LLC (Pet. Ex. 3)	$277.32
3. Preferred Open MRI (Pet. Ex. 4 at 2).	$4,500.00
Total Additional Medical Bills Payable:	**$5,985.09**

The Arbitrator finds these additional billed charges to be reasonable, necessary, and causally related to Petitioner's right leg injury dated February 18, 2019, arose out of his work activities with Respondent, and precede the MMI date of June 29, 2020. Respondent shall be entitled to receive a credit for any and all amounts previously paid pursuant to Section 8(j) of the Act.

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

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

As detailed *supra*, Petitioner sustained injuries to his right foot as a result of a work-related injury. As Petitioner's accident occurred on August 2, 2013, §8.1(b) of the Act applies. 820 ILCS 305/8.1b(b) of the Act requires consideration of five factors in determining permanent partial disability:

1. The reported level of impairment pursuant to section (a);
2. The occupation of the injured employee;
3. The age of the employee at the time of the injury;
4. The employee's future earning capacity; and
5. Evidence of disability corroborated by the treating medical records.

The statute provides that no single factor shall be the sole determinate of disability. The statute requires a written order explaining the relevance and weight of any factors used in addition to the level of impairment as reported by the physician. (Id).

1. Reported level of impairment:

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits, the Arbitrator will assess Petitioner's permanent disability based upon the remaining enumerated factors. *See Corn Belt Energy Corp. v. Illinois Workers' Compensation* Commission, 2016 IL App. (3d) 150311WC.

2. Petitioner's occupation:

The record reveals that Petitioner was employed as a laborer at the time of the accident. (Trans. at 11). Petitioner further testified that he was able to return to work in his prior capacity. No testimony was given as to whether Petitioner continues to work for Respondent. The Arbitrator therefore gives *greater* weight to this factor.

3. Petitioner's age at the time of injury:

The Arbitrator notes that Petitioner was 46 years old at the time of the accident. (Arb. Ex. 1). Petitioner's age places him in the near the middle of his work life expectancy, and therefore the Arbitrator gives this factor *some* weight.

4. Petitioner's future earning capacity:

The Petitioner has been released to return to full duty employment by his treating physician. (Pet. Ex. 2 at 33-35). Further, Petitioner's physicians have agreed that Petitioner's injury does not preclude him from returning to his pre-injury employment. (Id.). No testimony

was given as to whether Petitioner continues to work for Respondent. The Arbitrator gives *greater* weight to this factor.

5. Evidence of disability corroborated by the medical records:

The Arbitrator finds that Petitioner's condition of disability as of the MMI date is corroborated by the treating medical records and testimony entered into evidence.

At the time of his discharge from Dr. Anderson, it was noted that the peroneus longus and brevis tenons appeared to be intact and that the prior ATFL and CFL partial tears which had previously appeared in previous MRI's were no longer present. (Id.). Further, the persistent Achilles tendinopathy, which had been persistent throughout since the onset of this work injury, was similarly missing from the June 12, 2020 MRI. (Id. at 29-31).

Petitioner testified at trial that his foot does not feel normal and that it bothers him and swells when he walks. (Trans. at 19). When he climbs stairs, it also does not feel normal. (Id. at 19-20). Petitioner testified that prior to the work injury, he did not have any other accidents or injuries involving his right foot. (Id. at 20). Petitioner also testified that he was feeling better during the interval between his last visit to Dr. Tu and his first visit to Dr. Lipov – nearly 11 months later. (Trans. at 17-18). It also is noted that Dr. Anderson found that Petitioner's remaining pain in the right foot is not related to the work injury at issue in this case, and that Petitioner maintained a history of presenting pain in areas of injury which were not injured – according to all four MRI's and the various examining physicians.

The Petitioner's testimony, subjective complaints, objective findings and the opinions of the treating doctors and the independent medical examiner all support a permanent partial disability award of 7.5% loss of use of the right foot pursuant to Section 8(e) of the Act.

K. Prospective Medical

As the Arbitrator finds that the Petitioner was is at MMI as of June 29, 2020, the matter of prospective medical is moot and need not be addressed.

Signed: _____ 10/26/2020
SIGNATURE OF ARBITRATOR **DATE**

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC020038
Case Name	ADELSBERGER, CHARLES v. STATE OF ILLINOIS VIENNA CORRECTIONAL CENTER
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0398
Number of Pages of Decision	21
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Kenton Owens

DATE FILED: 8/5/2021

/s/ Kathryn Doerries, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES ADELSBERGER,

Petitioner,

vs. NO: 11 WC 20038

STATE OF ILLINOIS/VIENNA
CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION PURSUANT TO SECTIONS 19(h) AND 8(a)

This cause came before the Commission on Petitioner's Petition for Review pursuant to §§19(h) and 8(a), filed initially November 9, 2012, amended February 3, 2015, and notice given to all parties. Commissioner Luskin conducted a hearing in this matter on March 25, 2015, at which time counsel for Petitioner and Respondent were present and a record was made. Oral arguments were heard on the matter on January 24, 2017. Therein, the Commission ordered Respondent to pay the medical expenses attendant to both the left total knee replacement surgery and the right knee arthroscopic surgery pursuant to §8(a) of the Act, and subject to the Medical Fee Schedule under §8.2 of the Act, and that Respondent pay to Petitioner the sum of $730.75 per week for a period of 44 6/7 weeks, for the period of May 15, 2014, to March 25, 2015.

Petitioner filed the present Petition for Review pursuant to §§19(h) and 8(a), September 29, 2017. Oral arguments were heard on the Petition on June 8, 2021.

The current Petition presents the issues of whether the May 2020 surgery to the right knee is causally related to the April 20, 2011 accident and Petitioner seeks medical expenses related to that surgery, and wage differential/permanent partial disability.

In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the Petitioner's condition has changed materially since the time

of the Commission's first decision. *Gay v. Industrial Commission*, 178 Ill.App.3d 129, 132, 532 N.E.2d 1149, 1151 (1989).

After reviewing the record in its entirety and considering the issues of causal connection, medical expenses, and wage differential versus permanent partial disability, and being advised of the facts and law, the Commission finds that Petitioner failed to prove entitlement to a Section 8(d)(1) wage differential and awards permanent partial disability regarding Petitioner's right and left legs under Section 8(e)(12) of the Act. The Commission further finds that the Petitioner is entitled to the medical expenses related to the May 2020 right knee surgery as set forth below.

History from Prior Hearing

Petitioner was employed as a correctional officer for Respondent. On June 30, 2010, Petitioner sustained an injury to his left knee after he was involved in an inmate altercation. Petitioner subsequently underwent a left knee arthroscopic surgery consisting of partial medial and lateral meniscectomies, patellofemoral and medial compartment chondroplasties, and removal of a tibial eminence bone spur, on August 16, 2010. (Rx2) On December 2, 2010, his surgeon Dr. Milne opined that Petitioner was a candidate for a left total knee replacement (TKR). (Rx2) Petitioner was released to return to regular duty work and at maximum medical improvement (MMI) on February 15, 2011, with the Plan stating, "He knows he needs to try and delay TKR." Petitioner returned to full-time work for Respondent. Petitioner settled case number 10 WC 29796, for the June 30, 2010, injury, accepting 22.5% loss of use of the left leg for permanent partial disability (PPD) pursuant to §8(e) and closing his rights under §19(h) and §8(a). (Cx2, 6/22/12, Px5)

Petitioner was re-injured on April 30, 2011, when working in the accommodated position in the segregation unit for Respondent. As Petitioner was being relieved by his lieutenant, Petitioner turned to lock the door. Petitioner turned around to follow his lieutenant and slipped on water and fell. Petitioner testified that his right leg went forward, causing him to go down on his left knee and strike it on the concrete floor. Petitioner's left knee proved to be significantly symptomatic despite injections, use of an unloader brace, and undergoing additional conservative care. Dr. Michael Milne, who had observed the Petitioner both before and after the April 30, 2011 accident, explained that a knee replacement is for pain and that is the only reason you do a knee replacement. (CX2) Dr. Milne conceded that Petitioner would have needed a TKR due to his June 30, 2010 injury but opined that Petitioner's need for a TKR was likely hastened by the April 30, 2011 accident. (Cx2) Dr. Farley examined Petitioner at Respondent's request pursuant to Section 12. Dr. Farley opined that Petitioner's need for a left TKR had absolutely nothing to do with the April 30, 2011 incident. Dr. Farley felt Petitioner had lost a significant amount of cartilage which left him with "a bone on bone" problem and that would be a very painful condition. (Cx2)

June 22, 2012 Arbitration Hearing

At the Arbitration hearing on June 22, 2012, Petitioner described that, before the April 30, 2011 accident, his left knee was not perfect; he had knee pain and difficulty going up stairs. After the April 30, 2011 accident, the swelling in Petitioner's left knee was constant, he stated. Petitioner testified that he is in more pain and is uncomfortable, he is having a difficult time sitting still, he

has to continually adjust his position, and he is unable to walk long distances. He described increased popping, locking and stability issues in his knee. He also described losing his balance, taking pain medication, and being relatively inactive. (Cx2) The Arbitrator awarded Petitioner 45% loss of use of the left leg for the second left leg case on July 30, 2012, however, Respondent received credit for the previously received PPD award of 22.5% loss of use of the left leg. Applying the credit, Petitioner was awarded an additional 22.5% loss of use of the left leg for the second accident. The Commission (former Panel A composed of Commissioners Lamborn, Tyrrell and Donohoo) reviewed the Arbitrator's award and issued a Decision and Opinion on Review on May 8, 2013, affirming and adopting the Arbitrator's July 30, 2012, award.

Petitioner subsequently underwent a second left knee surgery consisting of a high tibial osteotomy to straighten his leg, an anterior cruciate ligament (ACL) reconstruction, partial lateral meniscectomy and chondroplasty of the trochlea and medial femoral condyle on May 15, 2014, performed by Dr. Nathan Mall. (Px7) Dr. Mall planned to also perform an osteochondral allograft transplantation as well as medial meniscus transplantation in the future to improve Petitioner's symptoms and ultimately postponing the left TKR. Dr. Mall testified it became apparent after the second surgery that Petitioner was not a candidate for cartilage restoration and that his next step for the left knee was the TKR. As of the date of Dr. Mall's deposition in March 2015 the left knee TKR surgery was scheduled for the following May 15, 2015. (3/11/15, Px3)

March 25, 2015 Commission Hearing on Petitioner's Sections 19(h)/8(a) Petition

Petitioner filed the prior petition under §19(h) and §8(a) and a hearing was held before Commissioner Luskin on March 25, 2015. The following evidence was adduced at that hearing.

Petitioner testified at that §19(h) Commission hearing on March 25, 2015, that following the appeal of the Arbitration Decision and receipt of the Commission Decision affirming and adopting the Arbitration Decision, he continued to have symptoms in the left knee including pain, swelling, weakness in the knee, the leg giving out, and the knee giving out when walking and standing. (T, p. 8) In late 2013, Petitioner's attorney referred him to Dr. Mall. Petitioner testified that within the last few months his right knee has started popping, swelling and he had stiffness, cracking in the joint and throbbing, dull pain. Petitioner also testified that he has fallen on his right knee as a result of his left knee giving out. (T, p.13, 15) Petitioner testified that he never had right knee problems prior to the deterioration of his left knee condition. (T, pp. 17, 18)

At Respondent's request pursuant to §12 of the Workers' Compensation Act, Dr. Michael Nogalski examined Petitioner and opined that the right knee condition was not causally related to the April 30, 2011, incident because there was nothing in his histories or his medical records which supports that these symptoms in his right knee would be related to physical therapy itself or an altered gait. Dr. Nogalski opined that Petitioner has osteoarthritis and chondral abnormalities in both knees that relate predominantly to genetic issues. (Rx7, p. 12) Dr. Nogalski also testified Petitioner was a candidate for a TKR of his left knee if he so chooses to move forward with that type of an approach to his knee at this point in time. (Rx7, p. 19)

Dr. Mall testified Petitioner is at a higher risk of developing knee symptoms on the contralateral side if there are symptoms on one side. (Px10, p. 17) Dr. Mall noted that Petitioner

had a right knee full-thickness cartilage defect of the medial femoral condyle, a focal defect about a centimeter wide and a centimeter long with an effusion present on the MRI. (Px10, p. 21) Dr. Mall opined that the Petitioner had an asymptomatic focal cartilage defect that became symptomatic after the Petitioner was on crutches and overloading the right leg. Dr. Mall testified the worsening of Petitioner's left knee overall as a result of his work accidents is what led to his right knee symptoms. Dr. Mall opined that because Petitioner was on crutches and having to put all of his weight through the right knee, the right knee is going to see a lot more load than it typically would if he had a normal left knee. Dr. Mall testified that both the 2010 and 2011 injuries played a role in aggravating the left knee and in the development of pain to the right knee. (Px10, pp. 23-25) Dr. Mall causally related the right knee to Petitioner's April 30, 2011, accident and recommended a right knee arthroscopy and debridement of the medial femoral condyle cartilage defect and assessment for future treatment in the right knee should Petitioner have continued complaints. (Px10, pp. 25-28)

The Commission, in the prior §19(h)/8(a) hearing, found Respondent responsible to pay the medical expenses attendant to both the left total knee replacement surgery and the right knee arthroscopic surgery pursuant to §8(a) of the Act, and subject to the Medical Fee Schedule under §8.2 of the Act, and that Respondent pay to Petitioner the sum of $730.75 per week for a period of 44 6/7 weeks, for the period of May 15, 2014, to March 25, 2015.

November 9, 2020 Commission Hearing on Petitioner's Present Sections 19(h)/8(a) Petition

Petitioner filed the current petition under §19(h) and §8(a) and a hearing was held before Commissioner Parker on November 9, 2020. The following evidence was adduced at that hearing. Oral arguments were heard before Commission Panel A on June 8, 2021.

Petitioner testified that he was employed as a correctional officer at SOI, Vienna Correctional Center (IDOC) at the time of the accidents. Petitioner began working at Vienna in February 1996. Petitioner is currently employed at St. Joseph's Hospital, Murphysboro, Illinois, as an x-ray/CT technician. He began that position June 15, 2020. (T.6.-8)

Petitioner testified that on April 30, 2011, he was injured while working for Respondent. The matter proceeded to hearing on June 22, 2012, and a decision was rendered. He received subsequent medical treatment and a second hearing was held on March 25, 2015. Petitioner received subsequent medical treatment post arbitration hearing. (T.8-9)

On the date of accident, April 30, 2011, Petitioner testified, he was relieved for his lunch break. Petitioner walked out with his supervisor into the hallway. Petitioner testified that an inmate must have just mopped the floor at that time. There were no 'wet floor' signs and the hallway was dark. Petitioner testified that his right foot slipped out in front of him and his left knee gave way and he came down onto his left knee. He fell on his back with his foot pinned behind his back which had twisted his knee. (T.8-9)

Petitioner came under care of Dr. Milne who performed surgery on 8/16/10. Petitioner testified that ultimately Dr. Milne recommended a total knee replacement. Petitioner came under

the care of Dr. Nathan Mall, who performed a high tibial osteotomy, total knee replacement of his left knee. (T.9-11)

Petitioner testified that while he was treating for his left knee, he developed symptoms in his right knee. (That had been addressed at the March 25, 2015 hearing.) Petitioner treated for his right knee. Initially Petitioner underwent a meniscal repair of the right knee. During that time, Petitioner was still having problems with his left knee and that had caused him to favor his right knee. Petitioner continued to follow up with Dr. Mall who continued to recommend treatment including therapy. Petitioner testified that the therapy had helped but caused pain. Dr. Mall recommended additional injections including PRP injections which were administered to his right knee. Petitioner testified the injection had helped for not quite a year (6-8 months). Petitioner testified that after that, the symptoms returned as they were before. (T.11-13)

Dr. Mall recommended additional testing of Petitioner's right knee. At that time, Petitioner was complaining of mechanical issues with his right knee including swelling, popping and clicking sounds. An MRI scan revealed Petitioner had another meniscal tear and Dr. Mall recommended another surgery for his right knee. Petitioner underwent right knee surgery on May 21, 2020. (T.13-14)

Following that surgery, Petitioner received additional physical therapy and reached MMI for his right knee on 7/1/20. Dr. Mall released Petitioner from medical care regarding the right knee on 7/1/20. No restrictions were imposed regarding the right knee. However, Petitioner did have restrictions regarding his left knee. Petitioner testified that as to his right knee, he no longer has symptoms. He was glad that he had right knee surgery. At this point he has no aches or pains with his right knee, and no issues with stiffness or swelling either. His right knee does stiffen up but does not swell as it had before the surgeries. Now it is very, very insignificant. (T.14-16)

Petitioner testified that while undergoing physical therapy for both knees, he had weakness in his left leg and that caused him to favor his right leg. Petitioner testified that he would put more weight on the right leg and he still puts more weight on the right. Petitioner testified that he cannot bear his full weight on his left knee. Petitioner currently weighs 220-225 pounds. (T.16-17)

Petitioner currently works as an x-ray technician performing x-ray and CT diagnostic imaging on patients. Petitioner's current position does not require him to be on his feet all day; he is able to alternate between sitting and standing and that helps his right knee. Petitioner testified sitting for prolonged periods will cause it to stiffen up as does standing for prolonged periods. Petitioner was not currently taking any medications for his right knee. (T.17-18)

On cross examination, Petitioner testified that regarding his left total knee replacement, he is currently on permanent restrictions. He is unable to return to his position as a correctional officer at Vienna; he agreed he was seeking a wage differential award. Petitioner did not recall the date of his first right knee surgery, and he did not recall when he was released at MMI regarding that first right knee surgery. (T.18-19)

Petitioner testified that prior to the 2011 left knee injury, he did not have any problems with his right knee. He had no other right knee workers' compensation cases other than this one.

Petitioner agreed that at some point he was released after the first right knee surgery. He never returned to Vienna as a correctional officer. He believed the last time he worked at Vienna as a correctional officer was March 2014. He did not recall the last date he worked there with no restrictions. From that time period, he did not work for any other employer [until hired as an x-ray /CT tech]. (T.19-21)

Petitioner agreed he went back to school through a vocational plan regarding his left knee injury. He obtained his radiology certificate for a Radiology Technologist. He attended Rend College as a full-time student from 2017-2019. Petitioner agreed that during that time period he was not actively involved in the work force. Petitioner agreed he started at St. Joseph's Hospital in June 2020 and he was currently working full time. (T.21-22)

On re-direct examination, Petitioner testified that with his current position he is working under the same permanent restrictions regarding his left knee. (T.22-23)

Petitioner presented the Petition for Review under Sections 19(h)/8(a) filed 9/29/17. The Petition noted Petitioner's left knee was injured on 4/30/11 and he thereafter developed an injury to his right knee due to overcompensating for the left knee. That Petition requested the Commission award medical expenses and prospective medical expenses necessitated by deterioration of his physical condition, as well as TTD and PPD. Petitioner requested the Commission review the prior award and enter an order for prospective medical expenses and payment of award related to Petitioner's 4/30/11 work injury. The exhibit included the 7/30/12 Arbitrator's decision and Commission decision affirming and adopting the Arbitrator's decision dated 5/8/13. (PX 2)

Medical bills were admitted for total bills, regarding both knees, of $291,914.51 for medical treatment rendered by Dr. Mall, SIH St. Joseph Hospital, Herrin Hospital, St. Louis Surgical Center, Orthopedic Ambulatory Surgery Center, physical therapy, and imaging/MRI. (PX 3)

The medical records of Dr. Nathan Mall show Petitioner returned for follow-up visit for his right knee on 1/20/20. Dr. Mall noted Petitioner's MRI revealed a lateral meniscal tear and he recommended a right arthroscopic surgery, partial meniscectomy, debridement & PRP injection right knee. The 5/21/20 operative report noted a right knee arthroscopic surgery was performed for a right medial meniscal tear. (PX 5)

Petitioner followed up on 6/3/20 and Dr. Mall noted Petitioner was ready to return to work as a radiology technician and he was to provide a full release regarding the right knee. Home physical therapy was prescribed. Dr. Mall saw Petitioner on 7/1/20 for follow up and he believed Petitioner had reached MMI regarding the right knee. The left knee was noted with Petitioner's permanent restrictions. Dr. Mall noted that Petitioner's right knee needed no further care. At the final visit on 8/5/20, Dr. Mall noted Petitioner was doing well and was working his new job in radiology. Petitioner was able to perform full duty in that capacity it was reported. Dr. Mall further noted Petitioner's left knee was functioning well. He recommended the same permanent restrictions and stated Petitioner was at MMI. (PX 6)

Reports of England & Company noted on 6/9/20 that Petitioner had completed a CT technician clinical and that Petitioner had his Associates Degree. It was noted Petitioner had been offered a position at SIH St. Joseph Memorial Hospital, Murphysboro, Illinois, earning $21.32/hour starting on 6/15/20. Their 7/16/20 report noted Petitioner was doing well with the radiology job which was physically appropriate for Petitioner. The final report dated 8/17/20 noted Petitioner was working and they closed their file. (PX16) Total bill for service dates 7/3/16 through 8/28/20 was $6,176.70. (PX17)

Deposition of Dr. Mall 8/24/20

Dr. Mall testified that he is an orthopedic surgeon licensed in Missouri. He is board certified in orthopedics in sports medicine and shoulder surgery. He identified his CV. He sees patients throughout the week and performs 10-15 surgeries per week, from knee to shoulder replacement surgery. He also treats hands and wrists for CTS, trigger finger conditions, as well as hip and ankle conditions. He sees about 150 patients per week. About 70% of his practice involves patients with work injuries, including both Illinois and Missouri cases. He has authored publications in his practice, but none lately. He performs IME's, usually at the request of insurance companies or defense attorneys. He has performed IME's at the request of Petitioner's attorney here. (PX18, T.4-7)

Dr. Mall examined Petitioner and kept records as with all patients as to care and treatment. He relies on those records and they help him for his opinions on cases. He had reviewed an IME of Dr. Nogalski (2/28/18) regarding Petitioner and a Commission decision from 4/13/17. Petitioner had been a patient of his for a number of years. He had initially seen Petitioner when he was at a different practice (10/13) but did not have those records anymore. The first record he had was from 4/17. He did have some independent recollection of the prior records before 2017. He understood Petitioner was seen regarding a work-related accident of 4/30/11. He had previously been deposed regarding this claim on 3/11/15. (PX18, T.7-9)

Dr. Mall agreed Petitioner underwent care and treatment that involved a left total knee replacement. He stated the first surgery was a high tibial osteotomy where he had to cut the bone and open it up for better alignment of the knee. He stated that is an attempt to treat arthritis in a younger person. He stated they did have to proceed with the total knee arthroplasty to resolve the arthritic issues in Petitioner's left knee. (PX18, T.9-10)

Dr. Mall testified that while he was treating Petitioner's left knee, Petitioner developed right knee symptoms and complaints. He recommended a course of treatment for the right knee as well. Dr. Mall testified that Petitioner's right knee condition became symptomatic as a result of the left knee condition. He stated at the time of the right knee complaints, Petitioner was on crutches for a long period of time. Petitioner had multiple surgeries on the left knee and appeared to have complete non-weight bearing on the left knee post-tibial osteotomy and, because of that increased stress, he felt the right knee condition became symptomatic. Dr. Mall had recommended surgery for the right knee, specifically a right knee arthroscopy and a partial meniscectomy debridement procedure. (PX18, T.10-11)

Dr. Mall agreed he had the opportunity to review the Commission decision of 4/13/17 and he had referenced it. He performed Petitioner's left knee total replacement surgery (5/15/15) related to this accident. He noted Petitioner had initially done well after the total knee replacement surgery. Dr. Mall noted Petitioner underwent multiple surgeries prior to the TKR and each major surgery fatigues the muscles quite a bit and it would take a long time to regain full muscle strength. But, he noted, Petitioner was continuing very well with it. Petitioner was building up substantial strength and last time he saw Petitioner it was essentially normal. Petitioner was able to resist [pressure] the same on both the left and right knees. He stated at the time he was not really recommending further treatment for the left knee, but after knee replacement, they typically monitor with surveillance x-rays about every 3 years and to make sure there is not asymptomatic loosening of the knee hardware. He stated not everyone follows that and a lot of people do not come back, but it is recommended. He stated Petitioner would not really be at MMI, but no additional treatment was needed. (PX18, T.11-13)

Dr. Mall testified he imposed permanent restrictions for the left knee on 2/12/16. At that time, he believed Petitioner would require treatment for the right knee, to include surgery, right knee arthroscopy, and a partial meniscectomy and chondroplasty procedure. Dr. Mall testified that he ultimately performed right knee surgery that the Commission found to be related to the 4/30/11 accident. (PX18, T.13-15)

Dr. Mall saw Petitioner on 6/26/17. He noted Petitioner had undergone the right standard knee arthroscopy and reported soreness and a little swelling in the knee, but otherwise he was doing well. He recommended physical therapy at that time. He next saw Petitioner on 8/3/17 and Petitioner was having a little trouble getting the quadriceps strength back in the left knee, but overall, he felt his symptoms improved. His right knee strength had returned nicely; 5 out of 5 strength bilaterally. He discussed possible treatment options for the right knee, i.e., PRP injections in the future given the degenerative findings of mild osteoarthritis in the knee. At that time, he placed Petitioner at MMI for the right knee. (PX18, T.15-16)

Dr. Mall stated Petitioner was doing well at that time but may require the injection. He still had some muscle weakness in the left knee, and it was the same issue with putting more stress on the right knee due to the left. Dr. Mall stated that it was dramatically better; pain was much better than before surgery, but he was still concerned that it would become symptomatic. He saw Petitioner on 2/5/18 and Petitioner complained of some clicking in the right knee. Dr. Mall recommended observation to see if it would get worse or better over time, but he was having some right knee symptoms already and he wanted to monitor that over time. He placed no restrictions on Petitioner's right knee in 2017. Petitioner was to return on 2/5/18. The condition was stabilized and looking good at that point. (PX18, T.16-17)

Dr. Mall testified that on 2/5/18 Petitioner returned reporting some right knee complaints. Petitioner also underwent a left knee x-ray examination to evaluate the left total knee replacement. He noted the left knee was actually doing better at that time and strength had returned. He again noted the right knee had some clicking and they discussed monitoring it rather than administering a PRP injection. (PX18, T.17-18)

Dr. Mall testified Petitioner returned in 8/18 and saw Dr. Mall's nurse practitioner. Dr. Mall next saw Petitioner 10/18 and Petitioner reported continued mechanical symptoms, including catching and popping in the right knee and he wanted to proceed with the PRP injection. The injection is rich in plasma from the patient, he testified, and it has various healing factors. He has offered it to other patients in his practice for a long time. He stated trial research showed the PRP treatment is better for the condition than a gel injection. He administered the injection that day. (PX18, T.18-19)

Dr. Mall reviewed the 2/28/19 IME report of Dr. Nogalski, as well as the 7/15/20 report. He agreed that in those reports Dr. Nogalski continued to believe Petitioner's left knee condition and need for a total knee replacement were unrelated to the work accident. Dr. Mall stated he disagreed with that opinion. Dr. Mall stated that Petitioner had a really significant injury to the left knee and had multiple surgeries. Dr. Mall stated Petitioner was clearly symptomatic after the 2011 injury that necessitated ongoing care and treatment. He stated given Petitioner's young age, attempts were made to treat his condition using more conservative treatment, but ultimately a left total knee replacement was performed due to the accident. (PX18, T.27-28)

Dr. Mall testified he did not think Petitioner's right knee condition was caused by the accident, but he believed that the extra stress put on the right knee by the multiple surgeries to the left knee, the periods of non-weight bearing [on the left knee] and periods of significant limping and muscle weakness, would certainly aggravate an underlying problem with the right knee. He would disagree with Dr. Nogalski's reading of the MRI scan that there were no objective findings on MRI. Dr. Mall stated, as he noted in his reports, he saw a clear medial femoral condyle cartilage flap and lateral meniscus tear. He stated he also found those findings at the 5/21/20 surgery as well as additional findings. Dr. Mall testified that those objective findings were consistent with Petitioner's symptoms and complaints prior to surgery. He testified that based on what Petitioner reported, it did appear as if Petitioner had reached a baseline regarding the right knee, as Dr. Nogalski said. (PX18, T.28-29)

Dr. Mall testified that he had billed for his services as a result of Petitioner's care and treatment. The medical bills were reasonable and necessary and similar to services in the medical community (GEOZIP). The off-work restrictions were related to that care and treatment and causally related to the 4/30/11 injury. He testified he believed the medical treatment was causally related to the accident. (PX18, T. 29-30)

Deposition of Dr. Nogalski 11/2/20

Dr. Nogalski testified he is board certified in orthopedics and licensed in Missouri. About 40% of his orthopedic practice involves treatment for knees, about 40% involves shoulders. He identified his CV. In his practice he performs independent medical evaluations and he saw Petitioner 3 times for an IME. (RX 2, T.5-7)

Dr. Nogalski last saw Petitioner on 7/15/20. He testified he reviewed Petitioner's medical records and authored his report (dep RX 2). He identified dep RX 3 as his 2/28/18 IME report, detailing his impressions and review of records. He identified dep RX 4 as the patient intake sheets

for 7/15/20 and 2/28/18. He identified dep RX 5 as his 7/7/20 letter from TriStar regarding the IME. (RX 2, T.7-9)

Dr. Nogalski noted at the time of the 2/28/18 visit, Petitioner had not been working. Up to about a month before the visit, Petitioner had retired from his job as a correctional officer. He believed Petitioner's retirement date was about 3 years before the 7/15/20 visit. He noted Petitioner received a right knee PRP injection on 2/28/18 and he reported that the injection had helped a lot. He noted that over the months, Petitioner started having increasing problems with the same issues of popping, swelling and soreness in the knee. Dr. Nogalski noted Dr. Mall had recommended further evaluation with an MRI scan and then recommended another arthroscopy of the right knee which was subsequently done 5/21/20. Petitioner reported that surgery had helped considerably and Petitioner also had another PRP injection during surgery. Petitioner then was able to do pretty much anything with the right knee. Dr. Nogalski believed Petitioner had been back to normal before he started having knee problems again. (RX 2, T.9-10)

Dr. Nogalski noted the radiologist who read the MRI indicated the 2020 MRI showed inner pre-margin radial tear mid lateral meniscus posterior form, medial and lateral femoral grade 3-4 chondrosis with a 12X10mm grade IV chondral defect inner posterior aspect femoral condyle. Dr. Nogalski testified he had reviewed the MRI film himself. He noted it was completed after the prior surgery and showed possible small meniscal irregularity posterior lateral meniscus and diffuse chondromalacia both lateral and femoral condyles with more pronounced change posterior aspect lateral femoral condyle. He indicated the diffuse chondromalacia he saw was a breakdown of the joint surface of the knee. Dr. Nogalski testified there was nothing wrong in the right knee that needed to be surgically addressed. (RX 2, T.10-12)

Dr. Nogalski had taken diagnostic quality x-rays at the time he examined Petitioner. He stated they showed relative neutral alignment and well-preserved joint space in the right knee. There were some mild degenerative changes in the patellofemoral joint in the right knee. X-rays of the left knee were also completed. (RX 2, T.12)

Dr. Nogalski examined Petitioner on 7/15/20 and he found Petitioner's right knee did not show any abnormal fluid or adhesions. He noted full extension and flexion to 140 degrees and the ligament stability was intact. Meniscal signs were negative, there was no tenderness, no crepitus, no tenderness to patellofemoral compression, and neurovascular exam was intact on the right. (RX 2, T.12-13)

Dr. Nogalski agreed Petitioner had a right knee arthroscopy. The MRI showed chondromalacia and grade IV changes. He testified that finding usually takes several years to develop. Prior to seeing Petitioner in 7/15/20, Petitioner had surgery to the right knee on 5/21/20. Dr. Nogalski opined that the 5/21/20 surgery was not related to Petitioner's 4/30/11 work accident. He believed at his 7/15/20 exam, Petitioner had reached MMI regarding the right knee. (RX 2, T.13-14)

Dr. Nogalski examined Petitioner previously on 2/28/18. Dr. Nogalski noted Petitioner reported that during that period he had noticed some popping, clicking and soreness at the end of the day. He noted no catching or locking symptoms. He noted at that time Petitioner had received

a PRP injection to try to prevent anything like the left knee. He stated the PRP injection is a relatively new technology that has mild to moderate support in the literature to help pain relief. At that time, Petitioner had been placed at MMI for the right, but still had permanent restrictions for the left knee. Dr. Nogalski stated a PRP injection was not a common thing after a medial meniscectomy. He stated it was not reimbursed by many insurance carriers as there was not enough evidence it specifically helps patients. (RX 2, T.14-16)

Dr. Nogalski indicated that after the 2017 surgery, Petitioner had restrictions of 40 pounds with no squatting and no kneeling. Petitioner could not stand for long periods and had difficulty with the left knee because of the nerve damage and the inside muscle not working. (RX 2, T.16-17)

Dr. Nogalski stated Petitioner told him he was going to school full-time and he had resigned as a correctional officer. He noted Petitioner had just started a new job as a radiology technician a couple months before the visit. Petitioner had been going to school and had restrictions. He indicated that by not working the jail gallery, he would have less stress on the knee. (RX 2, T. 17-18)

Dr. Nogalski opined that the 5/21/20 surgery was not causally related to Petitioner's work injuries from the 4/30/11 accident. He indicated any mechanical issues or problems would have been addressed by the 6/17/17 surgery. He testified in his opinion it was unreasonable to consider the right knee was re-injured or stressed due to the left knee; he indicated there is literature regarding that. (RX 2, T.18-19)

The issues presented before the Commission in the present Section 19(h)/8(a) Petition are causal connection, medical expenses, wage differential or in the alternative, permanent partial disability.

Having carefully reviewed the entire record, the Commission finds that Petitioner proved by a preponderance of the evidence his conditions of ill-being in his right and left legs are causally related to the April 30, 2011 accident. Consistent with the prior Commission decision, the Commission relies on the opinion of Dr. Mall. Dr. Mall testified that while he was treating Petitioner's left knee, Petitioner developed right knee symptoms and complaints. Dr. Mall testified that Petitioner's right knee condition became symptomatic as a result of the left knee condition. He stated at the time of the right knee complaints, Petitioner was on crutches for a long period of time for the left knee. Petitioner had multiple surgeries on the left knee and appeared to have complete non-weight bearing on the left knee post-tibial osteotomy and, because of that increased stress, he felt the right knee condition became symptomatic. Dr. Mall had recommended surgery for the right knee, specifically a right knee arthroscopy and a partial meniscectomy debridement procedure. (PX18, T.10-11)

The Commission further finds the second right knee surgery of 5/21/20 to be causally related to the 4/30/11 accident. The Commission relies on Dr. Mall's opinion that Petitioner's right knee condition became symptomatic as a result of the work-related left knee condition. The treatment rendered to both knees, therefore, was reasonable and necessary to cure or relieve the effects of the work-related injury.

The Commission, in finding the need for the 2nd right knee surgery to be causally related to the work-related accident, finds Petitioner entitled to an award for the reasonable, necessary and causally related medical expenses as exhibited in PX 3, specifically the right knee surgery of 5/21/20, as the expenses related to the left knee and the 1st right knee surgery had been awarded in the prior Commission decision. Respondent shall pay the medical expenses pursuant to Sections 8(a) and 8.2 of the Act and subject to the Medical Fee Schedule directly to the providers. Respondent shall receive credit for all medical expenses previously paid and Respondent shall hold Petitioner harmless for any claims for which Respondent is receiving credit.

The Commission notes the following as to determination of PPD regarding Petitioner's left knee and right knee. The Commission performs an analysis given the evidence and testimony presented herein. As Petitioner's accident occurred before §8.1b(b) of the Act being enacted, those factors are not addressed.

Petitioner suffered a left knee injury that required extensive conservative care, including injections, multiple surgeries and ultimately a total knee replacement resulting in permanent restrictions noted above. Petitioner is no longer working for Respondent as a correctional officer given his permanent restrictions. Petitioner was able to obtain his degree for a new career as a radiology technician and is currently working at SIH St. Joseph Memorial Hospital, in Murphysboro, Illinois. Petitioner subsequently developed the right knee condition that resulted in 2 arthroscopic surgeries but required no permanent restrictions.

> "The object of section 8(d)(1) is to compensate an injured claimant for his reduced earning capacity ***." *Smith*, 308 Ill. App. 3d at 265-66; see also *Rutledge v. Industrial Comm*, 242 Ill. App. 3d 329 (1993). To qualify for a wage differential award under section 8(d)(1), a claimant must prove (1) a partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) an impairment of his earnings. 820 ILCS 305/8(d)(1) (West 1998); *Greaney*, 358 Ill. App. 3d at 1014. To establish a diminished earning capacity, a claimant "must prove his actual earnings for a substantial period before his accident and after he returns to work, or in the event he is unable to return to work, he must prove what he is able to earn in some suitable employment." *Smith*, 308 Ill. App. 3d at 266. *Chlada v. Illinois Workers' Compensation Comm*, 2016 IL App (1st) 150122WC at 8

The Commission finds the England report, in and of itself, is insufficient to prove a wage differential award in this case. Petitioner testified he was requesting a wage loss but Petitioner's brief does not specifically address this argument. Of more significance, no check stubs were admitted into evidence to verify his radiology technician wages. By this evidence and testimony, or lack thereof, Petitioner has failed to meet his burden of proving entitlement to a Section 8(d)(1) wage differential award.

The Commission finds that Petitioner sustained a left knee injury that required multiple surgeries including a total knee replacement. Petitioner is on residual permanent restrictions preventing Petitioner from returning to his former position as a correctional officer. Petitioner has ongoing complaints regarding his left knee and needs to alternate positions on a regular basis to

limit ongoing symptoms. Petitioner's new position allows for alternating positions as needed. Based on the foregoing, the Commission finds that Petitioner sustained 65% loss of use of his left leg under Section 8(e)(12) of the Act, less credit for the prior 45% loss of use of the left leg award for a net award, herein, of a 20% loss of use of the left leg, under Section 8(e)(12) of the Act (43 weeks at $657.67 for a net total of $28,279.81).

The Commission, finding that Petitioner developed the right knee condition during the course and recovery from the work-related left knee condition, notes his right knee condition required 2 arthroscopic surgeries and Petitioner has reached MMI. Further, Petitioner is able to return to work with no restrictions for the right knee. Based on this, the Commission finds Petitioner sustained 12.5% loss of use of his right leg under Section 8(e)(12) of the Act (26.875 weeks at $657.67 for a total of $17,674.88).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay the medical expenses attendant to the second, May 2020 (as found in PX 3) right knee surgery pursuant to §8(a) of the Act, and subject to the Medical Fee Schedule under §8.2 of the Act and Respondent shall pay the medical expenses directly to the providers. Respondent shall receive credit for all medical paid and Respondent shall hold Petitioner harmless for any such applicable credit. The expenses related to the left knee and the 1st right knee surgery have previously been awarded in the prior Commission decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $657.67 per week for a net total period of 69.875 weeks, for the reason that the injuries sustained caused the 12.5% loss of use of Petitioner's right leg under Section 8(e)(12) of the Act (26.875 weeks at $657.67 for a total of $17,674.88), and caused the 65% loss of use of Petitioner's left leg under Section 8(e)(12) of the Act, less credit for the prior 45% loss of use of the left leg for a net award, of 20% loss of use of the left leg under Section 8(e)(12) of the Act (net 43 weeks at $657.67 for a net total of $28,279.81).

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

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

August 5, 2021

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

o-6/8/21
KAD/jsf

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0398

ADELSBERGER, CHARLES
Employee/Petitioner

Case# **11WC020038**

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

On 7/30/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
MOLLY WILSON DEARING
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
201 E MADISON ST SUITE 3C
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 30 2012

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

21IWCC0398

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

Charles Adelsberger
Employee/Petitioner

v.

SOI/Vienna Corretional Center
Employer/Respondent

Case # **11** WC **20038**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **6/22/12**. 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 **credit for prior settlement**

FINDINGS

On **April 30, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**56,998.00**; the average weekly wage was $**1,096.12**.

On the date of accident, Petitioner was **36** 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 $**all TTD paid** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**all TTD paid**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**657.67**/week for **48.375** weeks, because the injuries sustained caused the **additional 22.5%** loss of the **left leg**, as provided in Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services of $**5,790.08**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

7/30/12
Date

JUL 30 2012

Findings of Fact

Petitioner is a 36-year-old correctional officer for Respondent. The parties stipulated that Petitioner was involved in a work accident on April 30, 2011, and that Respondent received proper notice. Disputes include: whether Petitioner's current condition of ill-being is causally related to his April 30, 2011 injury, medical bills, nature and extent of the injury, and credit for prior settlement.

On April 30, 2011, Petitioner was injured when working in the segregation unit for Respondent. Petitioner was being relieved by his lieutenant when he was escorted through a door. When Petitioner turned to lock the door, he turned around to follow his lieutenant, stepped in some water, and fell. Petitioner testified that his right leg went forward, causing him to go down on his left knee and strike it on the dark concrete floor. He ended up with his foot underneath his body. Petitioner testified he had immediate burning in his knees, pain and symptoms.

Petitioner was involved in a prior work injury on June 30, 2010. Prior to June 30, 2010, Petitioner never had any knee complaints or problems performing his job. On June 30, 2010, Petitioner was involved in an inmate altercation when the batteries on his radio failed and he fought an inmate for over ten minutes, resulting in left knee injury. Petitioner required substantial left knee surgery and was released to return to full duty on February 15, 2011. Petitioner testified that he worked in the segregation unit from February 15, 2011 until the date of his new injury on April 30, 2011. Petitioner described the segregation unit as a jail within a jail. He spent much of his day on his feet walking the cell house to bring the inmates their lunch or to remove their trash. He also frequently kneeled and squatted to fasten leg irons on inmates who are being moved or to bring them things such as lunch or remove their trash. During Petitioner's time in segregation, he testified that he missed no time from work, did not use a knee brace, did not ice his knee, did not wrap his knee, and had no restrictions on his work or activities. When asked how his knee was doing during this time, he acknowledged that it was not perfect, but he felt it was getting stronger and moving in the right direction following surgery.

After his injury on April 30, 2011, Petitioner was escorted to the medical unit by his lieutenant. Two witness statements were completed and Petitioner completed a worker's compensation packet. After being looked at by the health care unit, he was advised to go to Herrin Hospital. At Herrin Hospital the history of the injury was that "*Patient slipped on wet floor and twisted left knee and landed on it.*" Petitioner was diagnosed with an acute injury of the left knee, sprain, and hypertension related to being frustrated and in pain. X-rays revealed tricompartmental osteoarthritis with no acute fractures and positive findings included joint effusion. Petitioner was given a left knee immobilizer.

Petitioner was seen in follow-up by Dr. Mark Austin at the Work Care Center by referral for left knee contusion and sprain. Dr. Austin performed an exam and reviewed an MRI. Dr. Austin found that Petitioner would not be able to squat or climb stairs. He restricted Petitioner to lifting, pulling, and pushing no greater than fifteen pounds and carrying for only short distances. He prescribed ibuprofen, Norco, ice, heat, and stretches. Petitioner was to avoid kneeling or squatting, avoid ladders and stairs, wear a splint, and was given a knee support with hinges. Petitioner was restricted from running, jumping, subduing or restraining inmates. Dr. Austin referred Petitioner back to Dr. Milne at the Orthopedic Center of St. Louis for examination.

Petitioner testified that he had difficulty obtaining worker's compensation approval for Dr. Austin's referral to Dr. Milne. Ultimately, a visit on July 5, 2011 was approved. At that time, Dr. Milne reported that Petitioner had a new injury on April 30, 2011 when he slipped on a wet floor and landed on the anterior aspect of his knee, causing a forced flexion. Petitioner reported that he had popping and locking since that time as well as constant global pain in the medial aspect of the knee and instability. Dr. Milne reiterated his restrictions of

no inmates, no stairs, a fifteen pound lifting limit, and no squatting. Examination revealed patella femoral crepitus and pain over the medial aspect of the left knee. Otherwise, the examination was normal. Dr. Milne's notes:

> *Charles describes mechanical symptoms with his knee that have changed from his most recent injury. He describes a hyperflexion and twisting mechanism.*

Dr. Milne recommended an MRI/arthrogram and continued light duty restrictions. Petitioner testified that he continued to work light duty in Respondent's mail room.

Petitioner returned to see Dr. Milne on August 9, 2011. Dr. Milne reviewed the MRI/arthrogram of his left knee and found that there was no recurrent medial meniscal tear, but there was a chronic anterior cruciate ligament deficiency and advanced degenerative joint disease of the medical compartment. Petitioner continue to report pain and swelling in his knee. Dr. Milne recommended a Synvisc One injection to try to improve him in a medial unloader brace. He indicated that Petitioner was not really a candidate for a total knee replacement due to his young age and that he may be benefited by a partial knee replacement, but he would really like to delay this as long as possible. Dr. Milne indicated that he would contact Sue Zellers with Central Management Services to obtain approval for the unloader brace and the injection. On October 13, 2011, in response to Petitioner's 19(b) Petition, the State of Illinois went on the record and approved Petitioner's request for an injection and medial unloader knee brace. Approval was sent to Dr. Milne's office.

On November 1, 2011, Petitioner returned for a Synvisc injection and medial unloader brace. Petitioner was continuing to work light duty and continued to report pain to the medial aspect of his knee. Examination revealed tenderness to Petitioner's medial and lateral joint line. Diagnosis was left knee pain and left knee osteoarthritis. Petitioner underwent a Synvisc injection and was measured for medial unloader brace. Dr. Milne planned to continue Petitioner's light duty restrictions until such time as he could obtain the brace.

On November 29, 2011, Petitioner returned to see Dr. Milne. Petitioner reported that the Synvisc One injection had given him no relief. Petitioner reported that the brace helped, but he continued to be restricted to working in Respondent's control room due to wearing the brace. Dr. Milne's impression was left knee stable post-operative care, left knee degenerative joint disease, left knee status post Synvisc One injection. Dr. Milne indicated that, although Petitioner had not received much benefit from the Synvisc One injection, it was early and he expected Petitioner to continue to improve. Wearing the knee brace and working in the control room was helpful for Petitioner. Dr. Milne reiterated that Petitioner should avoid a total knee replacement as long as possible due to his young age. Dr. Milne released Petitioner to continue to work his regular job duties in the control room and placed Petitioner at maximum medical improvement.

Petitioner presented the testimony of Dr. Michael Milne, who had been able to observe Petitioner both before the April 30, 2011 accident and afterward. Dr. Milne reported that when he last saw Petitioner on February 15, 2011, he did not give him any bracing and advised he could use over the counter anti-inflammatory medication or occasional pain medication, but did not feel he needed any additional treatment for his work injury. Dr. Milne opined that Petitioner's April 30, 2011 injury aggravated his underlying condition and obviously caused him to seek care again due to his increased pain. Dr. Milne explained that a knee replacement is for pain and that is the only reason you do a knee replacement. He felt that the second injury took a relatively non-painful, arthritic knee and made it a painful, arthritic knee. He believed that Petitioner would likely need a total knee replacement. He conceded that Petitioner would have needed a total knee replacement due to his June 30, 2010 injury, but opined that Petitioner's need for a total knee replacement was likely hastened by the April 30, 2011 accident. When asked on cross-examination whether he would agree that Petitioner's prognosis or future anticipated plan of treatment had not changed after the accident of April 30, 2011, Dr. Milne stated:

> *Well, when I saw him back, we offered Synvisc injections, did a cortisone injection, and gave him a knee brace, which we didn't do any of those things when I last released him in February.*

When asked whether his prognosis had changed after the April 30, 2011 accident, Dr. Milne stated:

> *I think he is proceeding down the path to a knee replacement faster than he was when I last saw him on February 15, 2011, as evidenced by the fact that he has now had cortisone injections, Synvisc One injections, and is using a medial unloader brace.*

Respondent had Petitioner examined by Dr. Timothy Farley pursuant to Section 12. Dr. Farley reviewed Petitioner's medical records and noted the history of both the June 30, 2010 and April 30, 2011 work injuries. Dr. Farley opined that Petitioner's current condition in his left knee is unrelated to the alleged incident of April 30, 2011. He believed:

> *Treatment I would recommend specific to April 30th is really nothing. Treatment related to his underlying arthritic condition in a young individual would be to maximize non-surgical methods with different injection theories, weight loss program, anti-inflammatories, and pain medication, if required. And should that fail, his really only good option at this point unfortunately is total knee replacement, given the profound level of arthritic change.*

Dr. Farley opined that Petitioner's need for a total knee replacement had absolutely nothing to do with the April 30, 2011 incident. He noted that Dr. Milne had commented in December of 2010 that Petitioner would have been a candidate for a total knee replacement. Dr. Farley described Petitioner's left knee as having a loss of cartilage within the joint due to arthritis. Dr. Farley felt Petitioner had lost a significant amount of cartilage with left him with a bone on bone problem and that would be a very painful condition. Petitioner was described as having really no cartilage remaining in the vast majority of the weight bearing portion of his knee and he believed that it took Petitioner decades to get into that condition. Dr. Farley indicated that he performs total knee replacements on far less arthritic knees every month. Dr. Farley opined that Petitioner would have difficulty in challenging environments including dealing with violent, young, strong prisoners and that the arthritis in his left knee may put him in harm's way.

On cross-examination, Dr. Farley admitted that Petitioner was released to return to work full duty on February 15, 2011 with no restrictions on his activities. He did not know whether Petitioner had ever gone to his primary care physician to obtain any pain medication, but was aware that Petitioner had no bracing, no wrapping, no restrictions on his ability to work overtime, no restrictions on his ability to stand for long periods of time, no restrictions on his walking, and no restrictions that he remain off of his feet. Dr. Farley was unaware that Petitioner had not missed any work and was working normally from February 15, 2011 to April 30, 2011.

At trial, Petitioner described the difference between in his knee before and after the April 30, 2011 accident. Petitioner described that prior to the April 30, 2011 accident, his knee was not perfect. He did have knee pain and difficulty going up stairs. After the April 30, 2011 incident, Petitioner described his knee swelling as constant. He is in more pain and is uncomfortable, having a difficult time sitting still. He has to continually adjust his position and is unable to walk long distances. He said that on some days, the pain was minimal, but on others, he just wants to lie down and cry. He described had increased popping, locking, and stability issues in his knee. He also described losing balance, taking pain medication, and being relatively inactive. The

Arbitrator notes that the biggest change Petitioner experienced after his April 30, 2011 accident is his use of a medial unloader brace.

Petitioner testified that he wakes every morning and puts on a large knee brace that contains five straps and several screws. One time per week, Petitioner is required to tighten the screws to give him better alignment of his knee. The Arbitrator observed during trial that Petitioner has difficulty sitting still and difficulty positioning his knee while sitting and moving from a seated position. Petitioner testified that prior to the April 30, 2011 incident he wore no such device on his knee. He did not go to the doctor to request one, nor did he have any complaints referable to his knee while working in segregation which required him to squat and kneel on the floor to apply leg irons to dangerous prisoners. Petitioner's right knee remains asymptomatic.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner's condition is causally connected to the undisputed accident from April 30, 2011. This finding is supported by the Petitioner's credible, unrebutted testimony and the medical records. The Arbitrator finds persuasive the opinions of Petitioner's treating physician, Dr. Milne in this regard.

2. Respondent shall pay Petitioner permanent partial disability benefits of $657.67/week for 96.75 weeks, because the injuries sustained caused the 45% loss of the left leg, as provided in Section 8(e) of the Act. However, Respondent shall receive a credit for Petitioner's prior settlement under case number 10 WC 29796 in which Petitioner received permanent partial disability amounting to 22.5% of his left leg, in the total amount of $31,015.63. Applying the credit, Respondent shall pay Petitioner permanent partial disability benefits of $657.67 week for 48.375 weeks, because the injuries sustained caused the additional 22.5% loss of the left leg, as provided in Section 8(e) of the Act.

3. Petitioner medical treatment, as set forth in the records, is reasonable, necessary, and causally related to the accident. Although Petitioner may need a total knee replacement in the future with regard to this left knee, and Respondent's physician agrees that such a procedure may be necessary, Petitioner's current medical care and treatment to avoid and prolong the procedure as long as possible is certainly reasonable and necessary. As a result, Respondent is ordered to pay the medical bills contained in Petitioner's group exhibit pursuant to Sections 8(a) and 8.2, subject to the Medical Fee Schedule. Respondent shall receive credit for any and all amounts previously paid. However, if Petitioner's group health carrier requests reimbursement, Respondent shall indemnify and hold Petitioner's harmless.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC019146
Case Name	STARK, RANDY v. USF HOLLAND
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0399
Number of Pages of Decision	21
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Julie Pagano

DATE FILED: 8/5/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0399

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randy Stark,

Petitioner,

vs. NO: 17 WC 19146

USF Holland,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by both parties herein and notice given to all parties, the Commission, after considering causal connection, medical expenses, prospective medical treatment, and temporary total disability ("TTD") benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission modifies the temporary total disability benefits awarded by the Arbitrator. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Facts

On July 3, 2017, Petitioner filed an Application for Adjustment of Claim in case 17 WC 19146 alleging a date of accident of August 25, 2016. That same day, Petitioner also filed an Application for Adjustment of Claim in case 17 WC 19312 alleging a date of accident of June 22, 2017. The cases were consolidated and both cases proceeded to hearing on January 24, 2020. The parties executed a single Request for Hearing form that addressed both cases. The Arbitrator filed a single Decision that addressed any pending issues in both cases. The Commission has issued a separate Decision in case 17 WC 19312.

The parties stipulated that Petitioner's current condition of ill-being and continued medical treatment relating to Petitioner's development of extensive deep vein thrombosis ("DVT") and pulmonary emboli are not in dispute. Respondent does not dispute that most Petitioner's ongoing complaints regarding his right leg are residual symptoms of the chronic DVT he developed. This present matter concerns the causal connection and medical treatment solely relating to Petitioner's ongoing right knee complaints. Respondent stipulated that Petitioner's right knee condition

remained causally related to the work accidents through July 31, 2019. Respondent also does not dispute the causal connection and reasonableness and necessity of medical treatment Petitioner underwent relating to the right knee through July 31, 2019.

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. Petitioner sustained a work-related injury to his right calf on August 25, 2016. Following that work accident, Petitioner returned to work without restrictions in April 2017. On June 22, 2017, he sustained a second work-related injury to his right calf and his right knee. Dr. Paletta, Petitioner's treating physician, diagnosed Petitioner with a chronic right medial gastrocnemius strain and a right medial meniscus tear. A June 2017 MRI of the right knee had the following impression: 1) radial tear near the inner margin root attachment posterior horn medial meniscus with nonspecific linear intrasubstance signal extending from the anterior horn through the body into the posterior horn; and 2) patellofemoral chondromalacia with mild joint effusion with no loose body formation and distal semimembranosus insertional tendinitis/tendinopathy with small adjacent developing Baker's cyst. On February 20, 2018, Petitioner underwent right knee surgery that included the following procedures: 1) arthroscopy with debridement of chondroplasty, medial tibiofemoral compartment; 2) debridement of chondroplasty, patellofemoral compartment; 3) repair of medial meniscus root avulsion; and 4) open medial meniscotibial ligament repair. The postoperative diagnoses were right knee pain with tibial ligament insufficiency, posterior horn medial meniscus root avulsion tear, medial compartment early degenerative joint disease, and patellofemoral chondromalacia.

Unfortunately, Petitioner's postsurgical recovery was significantly complicated by his development of an extensive acute DVT in the right leg and pulmonary emboli in April 2018. Petitioner continues to suffer from the residual effects of the DVT and pulmonary emboli and continues to see a vascular surgeon for these conditions. In December 2018, Petitioner complained of mild discomfort in his knee to Dr. Paletta. The doctor wrote that he was unsurprised by Petitioner's continued mild right knee pain due to Petitioner's medial compartment degenerative joint disease in the knee.

A January 2019 MRI of the right knee had the following impression: 1) complex nondisplaced tear throughout the body and posterior horn of the medial meniscus with possible postsurgical changes involving the posterior horn of the medial meniscus possibly related to the prior medial meniscus repair; 2) no acute ligament injury; 3) mild medial compartmental osteophytosis; and 4) small focus of grade IV chondrosis involving the superior patellar apex. Dr. Paletta last examined Petitioner on March 13, 2019. At that time, Petitioner continued to complain of increasing right knee pain as well as significant symptoms relating to his DVT diagnosis. After reviewing the recent right knee MRI, Dr. Paletta determined there was clear medial compartment narrowing with progressive degenerative changes and progressive degenerative changes of the patellofemoral joint. He recommended Petitioner undergo a right total right knee replacement to address Petitioner's ongoing right knee complaints. Dr. Patella referred Petitioner to Dr. Nunley for a consultation regarding a possible knee replacement surgery. Petitioner has continued to receive chiropractic treatment and physical therapy from the medical practice of Dr. Eavenson, Petitioner's treating chiropractor.

Petitioner testified that he continues to experience pain and swelling in his right leg and

now walks with a cane. He testified that he feels immense pain in his right knee while walking and must take care, so the knee does not give out. Petitioner testified that he wants to pursue the consultation with Dr. Nunley regarding a possible right knee replacement. He testified that his right knee pain can rate as high as 9/10.

Petitioner testified that he underwent a right knee surgery approximately 27 years earlier. He denied having any problems with the knee when he began working for Respondent and passed the required Department of Transportation physical. Petitioner denied missing any work before these injuries due to any problems with his right knee. He admitted that he was diagnosed with right knee arthritis before either of these work injuries.

Dr. Paletta opined both in a narrative report he prepared at the request of Petitioner's counsel and during his evidence deposition that any knee symptoms Petitioner currently experiences relate to Petitioner's underlying degenerative osteoarthritis. Dr. Paletta further opined that the need for a total right knee replacement relates to the preexisting osteoarthritis. Dr. Paletta testified that the January 2019 right knee MRI revealed that Petitioner was down to bone-on-bone in the knee. He testified that in December 2018, he determined Petitioner's residual knee symptoms related to the underlying arthritis.

Dr. Ritchie examined Petitioner pursuant to Section 12 of the Act on May 21, 2019, at the request of Respondent. He prepared a written report and testified via evidence deposition. After examining Petitioner and reviewing medical records, he opined that Petitioner's ongoing right knee complaints relate to the continued degenerative changes in the knee. He opined that Petitioner's complaints and the possible necessity of a right knee replacement are not related to either work accident. Dr. Ritchie opined Petitioner had reached maximum medical improvement ("MMI") for the right knee regarding the work accidents and any work restrictions would relate to either Petitioner's DVT condition and/or his degenerative arthritis.

Dr. Barkmeier examined Petitioner pursuant to Section 12 of the Act on April 16, 2019, at the request of Respondent. The doctor prepared a written report and testified via evidence deposition. Dr. Barkmeier diagnosed Petitioner with right leg chronic venous insufficiency secondary to deep vein thrombosis as a sequela of the acute DVT. She opined that Petitioner did not require any work restrictions due to his chronic venous insufficiency. However, she opined that Petitioner would need to elevate his leg during work and lunch breaks three times for ten minutes each time during the workday. Dr. Barkmeier testified that Petitioner would be able to perform his regular work duties. The doctor further testified that Petitioner would be able to return to full duty work in his normal position even if Respondent could not accommodate her recommendation regarding Petitioner's need to elevate his leg during the workday. Dr. Barkmeier testified that Petitioner would be more comfortable if he were able to elevate his leg as recommended; however, she has plenty patients who are not able to follow this recommendation. Patients who are unable to follow her recommendation regarding elevating the leg during the workday may experience uncomfortable swelling particularly at the end of the day.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the

evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). When a claimant suffers from a preexisting condition, the claimant must show that a work-related accidental injury aggravated or accelerated the preexisting condition "…such that the [claimant's] current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *Id*. at 204.

After carefully considering the evidence, the Commission affirms the Arbitrator's conclusion that Petitioner failed to meet his burden of proving his current condition of ill-being regarding his right knee is causally related to either work accident. The Commission also affirms the Arbitrator's denial of prospective medical care in the form of an evaluation by Dr. Nunley. There is ample evidence supporting the conclusion that the current condition of Petitioner's right knee is not causally related to the work injuries. This includes the medical records and opinions of Petitioner's treating physician, Dr. Paletta. Dr. Paletta notably opined that Petitioner's ongoing right knee complaints no longer relate to the work injuries; instead, Petitioner's complaints now relate to the preexisting degenerative arthritis in that knee. Furthermore, Dr. Paletta opined that Petitioner's potential need of a right knee replacement also relates to the preexisting arthritis. Dr. Ritchie, Respondent's Section 12 Examiner, agrees with these opinions. Finally, the Commission affirms the Arbitrator's conclusion that any causal connection of Petitioner's right knee condition to the work accidents ceased after July 31, 2019.

After reviewing the evidence, the Commission must modify the Arbitrator's award of TTD benefits for the period of September 4, 2019, through January 24, 2020, for a total of 20-3/7 weeks. Petitioner sought TTD for the periods of June 23, 2017, through July 16, 2017, February 25, 2018, through April 4, 2018, and September 4, 2019, through January 24, 2020, for a total of 29-3/7 weeks. The parties stipulated that Respondent owes TTD benefits for the period of February 25, 2018, through April 4, 2018.

The Commission finds that Petitioner has failed to prove an entitlement to TTD benefits for the periods of June 23, 2017, through June 25, 2017, and September 4, 2019, through January 24, 2020. Respondent sustained his second work injury on June 22, 2017; however, he did not seek medical treatment until June 26, 2017. On that date, the doctor took Petitioner off work due to his injury. There is no evidence that any medical provider prescribed any work restrictions relating to this second work accident before June 26, 2017. Thus, the Commission finds Petitioner's entitlement to TTD began on June 26, 2017. An examination of the payment ledger submitted by Respondent reveals that it has already paid TTD for the period of June 26, 2017, through June 29, 2017. (RX 1). Therefore, Respondent is liable for TTD benefits for the period of June 30, 2017, through July 16, 2017, or 2-3/7 weeks.

Due to the Commission's finding that Petitioner's current condition of ill-being regarding his right knee is not causally related to either work accident, the Commission must vacate the Arbitrator's award of TTD benefits from September 4, 2019, through January 24, 2020. Petitioner's right knee condition was causally related to the work injuries only through July 31, 2019. Thus, Petitioner is only entitled to TTD benefits after that date if the evidence reveals a doctor has restricted Petitioner from work due to his ongoing issues relating to his chronic DVT condition. The Arbitrator awarded TTD from September 4, 2019, through January 24, 2020, due to Petitioner's residual symptoms relating to the DVT and subsequent postphlebitic syndrome of

the right leg. While the Commission agrees that Petitioner continues to suffer significant residual symptoms due to his DVT condition, the Commission finds there is no evidence that any doctor has prescribed work restrictions due to the chronic DVT symptoms from September 4, 2019, through January 24, 2020. Additionally, Dr. Barkmeier, Respondent's Section 12 Examiner, opined that Petitioner is able return to his normal job without restrictions despite his ongoing symptoms relating the chronic venous insufficiency. Dr. Barkmeier credibly testified that Petitioner should take time to elevate his leg three times during the workday for 10 minutes each time. She further testified that Petitioner could return to work full duty even if Respondent is unable to accommodate her recommendation that Petitioner elevate his leg three times during the workday. There is no evidence that contradicts this opinion. Therefore, the Commission finds Respondent is liable for TTD benefits for the periods of June 30, 2017, through July 16, 2017, and February 25, 2018, and April 4, 2018, for a total of eight weeks.

Finally, the Commission corrects a clerical error in the Decision of the Arbitrator. On the Arbitration Decision Form, the Arbitrator wrote the arbitration hearing occurred on 01/20/2020. This is clearly a scrivener's error. The Commission thus modifies the above-referenced sentence to read as follows:

> The matter was heard by the Honorable Edward Lee, Arbitrator of the Commission, in the city of Collinsville, IL on 01/2**4**/2020.

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 March 25, 2020, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his right knee is not causally related to either the August 25, 2016, or June 22, 2017, work accidents. The Commission finds Petitioner's current condition of ill-being relating to his chronic DVT condition is causally related to the June 22, 2017, work accident.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $683.02/week for 8 weeks, commencing June 30, 2017, through July16, 2017, and February 25, 2018, through April 4, 2018, as provided in Section 8(b) of the Act. Respondent shall be given a credit for all temporary total disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges, as provided in Sections 8(a) and 8.2 of the Act. Respondent is not liable for any expenses for medical treatment provided after July 31, 2019, relating to Petitioner's right knee.

IT IS FURTHER ORDERED that prospective medical treatment in the form of the evaluation by Dr. Nunley at Washington University in St. Louis recommended by Dr. Paletta is

hereby denied.

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

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

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

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.

August 5, 2021

o: 6/8/21
TJT/jds
51

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

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

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

21IWCC0399

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

STARK, RANDY
Employee/Petitioner

Case# **17WC019146**
17WC019312

USF HOLLAND
Employer/Respondent

On 3/25/2020, 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 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

2904 HENNESSY & ROACH PC
PAUL N BERARD
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

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)

RANDY STARK
Employee/Petitioner

v.

USF HOLLAND
Employer/Respondent

Case # **17** WC **19146**

Consolidated cases: **17 WC 19312**

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, IL** on **01/20/2020**. 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 accidents, **08/25/2016 and 06/22/2017**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**52,275.73**; the average weekly wage was $**1,024.53**.

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 $**all TTD paid** for all TPD paid.

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

ORDER

Petitioner proved that his current condition of DVT sequelae in his right leg is causally related to his work injury.

Respondent shall pay reasonable and necessary medical services pursuant to the Medical Fee Schedule set forth in Petitioner's Exhibit 16.

Respondent shall pay Petitioner temporary total disability benefits of $683.02 for 20 3/7 weeks commencing September 4, 2019 to January 24, 2020 , as provided in Section 8(b) of the Act.

Petitioner's claim for prospective medical consisting of an evaluation with Dr. Nunley at Washington University is hereby denied.

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

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

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

Carl Lee — Signature of Arbitrator

3/19/20 — Date

ICArbDec19(b)

MAR 25 2020

FINDINGS OF FACT:

These claims were tried pursuant to Petitioner's Request for Hearing under Section 19(b) of the Act. The parties stipulated to both claims being consolidated at the time of hearing. The parties also stipulated that Petitioner sustained accidents that arose out of and in the course of his employment by Respondent. However, Respondent disputed that Petitioner's current condition of ill-being was causally related to his accidents, as well as its liability for medical expenses after July 31, 2019, and 29 3/7 weeks of TTD for various times periods indicated on Arbitrator's Exhibit 1. Petitioner is also seeking an award of prospective medical treatment consisting of an evaluation for a right total knee replacement with Dr. Nunley at Washington University.

Petitioner, a 55-year-old local delivery driver, sustained an accidental injury to his right calf on August 25, 2016. He testified that he was making a delivery of roll stock paper to a printing plan up on the Hill in St. Louis. (TR-13) As he was pulling the stock of paper down the sidewalk into the building, he felt something pull in his right calf. (TR-13) He testified he sought medical treatment and physical therapy until returning to work on April 20, 2017. (TR-14) He testified he was paid workers' compensation from the date of his injury through his return to work. (TR-14-15)

Petitioner testified that he had returned to full duty work with some occasional fatigue and soreness in his right calf towards the end of the days. (TR-15) He testified that on June 22, 2017, he was delivering a 700 or 900-pound skid of books to a school district in Arnold, and as he was pulling the pallet jack he felt his right knee pop and reinjured his right calf. (TR-15-16) He went to Gateway Occupational. (TR-15) He testified he had previously had a right knee surgery 27 years ago. (TR-16) Petitioner denied having any problems with his right knee prior to his employment at Respondent. (TR-17)

Petitioner testified he underwent right knee surgery on February 20, 2018. (TR-17) He was being paid workers' compensation at the time. (TR-18) He testified he developed blood clots in his right leg shortly after surgery. (TR-18) He was hospitalized twice and underwent treatment with several physicians. (TR-18-19) He is currently only seeing Dr. Fisher for follow up of his blood clots. (TR-19) Petitioner testified he currently has right knee pain and wants to be evaluated by Dr. Nunley at Washington University at the referral of Dr. Paletta for consideration of a right total knee replacement. (TR-22-23)

On cross-examination, Petitioner testified that he lived 28 miles from Respondent's terminal. (TR-24-25) He testified he was unable to drive his car to work light duty at Respondent in February and March 2018 because he had to wear a full leg brace. (TR-25) (TR-25-26) He testified that Respondent requested he return to his regular job on September 4, 2019. He testified that he was diagnosed with arthritis in his knee prior to either of his work injuries. (TR-27)

On August 25, 2016, Petitioner presented to Gateway Regional Medical Center ER after initially being evaluated at Gateway Reginal Occupational Health Services, Inc. He reported feeling something pop in his right lower leg while he was at work pulling a 900-pound object. Right knee x-rays revealed minimal degenerative osteoarthritis. Petitioner was diagnosed with a right calf strain and possible muscle tear. (PX 1 and PX 2)

On August 27, 2016, Petitioner sought care at BJC Medical Group Orthopedics and Sports Medicine for right calf pain. He was diagnosed with a right gastrocnemius muscle strain. He was taken off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on September 9, 2016. Physical therapy was prescribed and Petitioner was continued off work. (PX 3)

Petitioner presented for an initial therapy evaluation at Fyzical Therapy and Balance Centers on September 13, 2016. He completed 86 physical therapy sessions for his right calf through April 13, 2017. (PX 4)

On September 23, 2016, Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain. A right calf MRI was prescribed. Petitioner was released to work without restrictions on October 7, 2016. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on October 7, 2016. A right calf MRI revealed a partial grade 2 tear of his right gastrocnemius. Additional physical therapy was prescribed, and Petitioner was taken off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on November 4, 2016. He reported making significant improvement with therapy. Additional physical therapy was prescribed, and Petitioner was continued off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on December 2, 2016. He continued to improve but was still reporting difficult with walking more than 30 minutes. Additional physical therapy was prescribed, and Petitioner was continued off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on January 3, 2017. Petitioner was released to light office work with occasional walking or standing, occasional lifting up to 10 pounds and/or carrying articles like small clothes. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on January 27, 2017. He reported making significant improvements with his right gastric. He was able to walk 1.5 miles without pain. He was still unsure about being able to push and pull significant amounts of heavy weights. He did not think he was quite ready to return to work. His light duty restrictions were continued. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on February 17, 2017. He reported still being unable to pull up to 900 pounds, as he has only done 130 pounds in therapy. His light duty restrictions were continued. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on March 20, 2017. He reported now pulling up to 200 pounds in therapy. He requested additional therapy. His light duty restrictions were continued. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on April 17, 2017. He reported doing well since his last visit and feeling ready to return to work without restrictions. Petitioner was released to full duty on this day and discharged from care. (PX 3)

Petitioner began working his regular job duties again on April 20, 2017. Petitioner continued to work his regular job duties in May and June 2017. On June 22, 2017, he sustained another right knee and leg injury while delivering a 700 or 900-pound skid of books to a school district in Arnold. (TR-15-16)

On June 26, 2017, Petitioner presented to Multicare Specialists, PC, for right medial calf pain and posterior knee pain. Petitioner reported that a few days prior he was climbing into his truck and felt a pop in his right calf. Dr. Eavenson diagnosed a right medial gastrocnemius recurrent tear of the right knee. (PX 5)

Petitioner was evaluated at Gateway Regional Occupational Health Services, Inc. on June 26, 2017, as well. He reported a consistent history of sustaining a right calf injury on June 22, 2017. Petitioner was diagnosed with a right calf strain and swelling. MRIs of the right knee and right calf were prescribed. Petitioner was taken off work until one day after he undergoes the MRIs. (PX 1)

On June 27, 2017, Petitioner underwent a right calf MRI at MRI Partners of Chesterfield. The radiologist's impression was: (1) area of fatty replacement within the medial head of the gastrocnemius lipoma or from previous injury or denervation without evidence of tear; (2) small joint effusion and small Baker's cyst; (3) varicose veins; and (4) no evidence of stress reaction or stress fracture. (PX 6)

On June 28, 2017, Petitioner underwent a right knee MRI at MRI Partners of Chesterfield. The radiologist's impression was: (1) radial tear near the inner margin root attachment posterior horn medial meniscus with nonspecific linear intrasubstance signal extending from the anterior horn through the body into the posterior horn accompanying the aforementioned; (2) patellofemoral chondromalacia with mild joint effusion but no loose body formation; and (3) distal semimembranosus insertional tendinitis/tendinopathy with small adjacent developing Baker's cyst. (PX 6)

Petitioner underwent physical therapy and chiropractic care at Multicare Specalists from June 27, 2017, through January 21, 2020. Petitioner attended over 350 physical therapy and chiropractic sessions during this time. The total billed amount for this physical therapy and chiropractic treatment was in excess of $150,000.00. Respondent paid more than $86,000.00 for this physical therapy and chiropractic treatment. (PX 5 & 16)

On July 14, 2017, Petitioner presented to Dr. George Paletta, Jr. at The Orthopedic Center of St. Louis for right knee and right calf pain. He reported having a history of a right calf injury one year prior while moving a 900-pound pallet. Petitioner reported being reinjured on 6-22-17 when using a pallet jack to move a 700-pound pallet. He reported initially going back to work and his pain being worse each day. Dr. Paletta noted that Petitioner's primary complaints were in the medial gastroc. Dr. Paletta reviewed Petitioner's MRIs. Dr. Paletta's impression was (1) chronic medial gastroc strain with probable fatty infiltration versus intramuscular denervation and (2) early osteoarthritis in the right knee associated with radial tear of medial meniscus. Dr. Paletta recommended a right knee injection and EMG of the calf. Dr. Paletta opined Petitioner may need a right knee surgery. He recommended he continued with physical therapy. Petitioner was released with being able to bear weight as tolerated. (PX 7)

On November 2, 2017, Petitioner underwent an EMG at Neurological & Electrodiagnostic Institute, Inc. Dr. Phillips' impression was very mild distal diabetic type peripheral neuropathy. Study not impressive for additional right lower extremity traumatic neuropathy. (PX 9)

On November 8, 2017, Dr. Paletta authorized a report regarding Petitioner's recent EMG. Dr. Paletta opined that the testing demonstrated findings consistent with a mild distal diabetic type peripheral neuropathy. Dr. Paletta's impression was mild diabetic peripheral neuropathy. Dr. Paletta opined that there is no evidence of any specific neurologic injury. Dr. Paletta recommended a repeat MRI to determine whether surgery would be needed for the calf. He opined Petitioner would also require a right knee arthroscopy and partial meniscectomy. Dr. Paletta opined he was reluctant to recommend any surgery on the knee given the degree of symptoms in the gastroc. (PX 7)

Petitioner underwent a right calf MRI at MRI Partners of Chesterfield on January 12, 2018. The radiologist's impression was intramuscular lipoma within the distal gastrocnemius medial head measuring up to 5.2 by 6.4 and 2.3 cm and numerous large saphenous venous varicosities. (PX 6)

On January 25, 2018, Petitioner sought follow up care with Dr. Paletta for continued right knee pain. Dr. Paletta's impression was persistently symptomatic radial tear of medial meniscus of right knee with associated early medial compartment DJD. He recommended Petitioner undergo a diagnostic ultrasound with Dr. David Crane to determine what surgery would be most beneficial. (PX 7)

On February 5, 2018, Dr. David Crane at Bluetail Medical Group performed a diagnostic ultrasound of the right knee. His assessment was right knee pain, derangement of medial meniscus, osteoarthritis and pes anserinus bursitis. He opined Petitioner was a good candidate for meniscal extrusion/medial capsule repair followed by BMAC/fat autograft to the right knee. (PX 14)

On February 20, 2018, Dr. Paletta performed a right knee intraoperative diagnostic ultrasonography, diagnostic arthroscopy, debridement of chondroplasty of medial tibiofemoral compartment, debridement of chondroplasty of patellofemoral compartment, repair of medial meniscus root avulsion and open medial meniscotibial ligament repair. (PX 8; Ex. 2)

On March 5, 2018, Petitioner sought follow up care with Dr. Paletta for initial post-op evaluation. He reported doing well overall. Petitioner was released to light-duty of no lifting or material handling, and no pushing/pulling. (PX 7)

Petitioner began physical therapy and chiropractic care for his right knee at Multicare Specialists on March 6, 2018. He continued with therapy on March 7th, 8th, 12th, 15th and 19th. (PX 5)

On April 4, 2018, Petitioner sought follow up care with Dr. Paletta seven-weeks post-surgery. He reported having continued knee pain with intermittent swelling. Dr. Paletta's impression was residual effusion of right knee and mild motion loss status post meniscus root repair and medial meniscotibial ligament repair. Dr. Paletta recommended Petitioner continue with physical therapy. He released Petitioner to light-duty of no standing or walking more than 15 minutes per hour, primarily sedentary work, no lifting/pushing/pulling/carrying/squatting/kneeling/ladders or climbing and limit stairs to one flight per hour. (PX 7)

On April 10, 2018, Petitioner sought care at Multicare Specialists for therapy and chiropractic care. He reported having an increase in swelling in the right lower extremity. Dr. Eavenson diagnosed Petitioner with acute DVT of the right lower extremity. (PX 5)

On April 10, 2018, Petitioner underwent a vascular doppler ultrasound at Gateway Regional Medical Center. Dr. Patel's conclusion was (1) acute DVT involving right CFV, SFV, DFV, Popliteal vein and PTV; and (2) normal left lower extremity venous scan. (PX 10)

Petitioner presented to St. Luke's Hospital ER for shortness of breath and chest pain on April 16, 2018. He reported being diagnosed with DVT a week ago and being on Eliquis twice daily since. He reported developing right sided chest pain and dyspnea that is worse with walking. Petitioner was diagnosed with a pulmonary embolism, right leg DVT, Type 2 diabetes, hypertension, and hypothyroidism. He was admitted to the hospital and eventually discharged on April 18th. (PX 13)

On April 20, 2018, Petitioner presented to St. Luke's Hospital ER for knee pain. He reported being released two days prior but having his 80-pound dog hit him in his right knee with his tail and he started having pain and swelling again. He reported barely being able to walk. Right knee x-rays did not reveal any fracture. A vascular report found Petitioner to have evidence of acute DVT on the right. Petitioner was diagnosed with a traumatic hematoma of the right knee and discharged from the ER. (PX 13)

On May 8, 2018, Petitioner presented to Dr. Kristen Fisher at Cardio Pulmonary Associates follow up care for PE/DVT. Dr. Fisher noted that Petitioner had knee surgery in February and had persistent swelling in his right leg. Dr. Fisher diagnosed pulmonary embolism with right DVT provoked by recent knee surgery. She recommended at least six months of anticoagulation. Dr. Fisher also diagnosed DVT. She opined he has an extensive clot. She was not sure whether much could be done but referred Petitioner to a vascular surgeon for further evaluation. (PX 12)

On May 11, 2018, Petitioner sought follow up care with Dr. Paletta. Dr. Paletta noted that his post-op course has been complicated by Petitioner's proximal deep vein thrombosis with pulmonary embolism. Petitioner reported that his right knee was gradually improving. He no longer had a sharp stabbing pain. Dr. Paletta opined that Petitioner's right knee is gradually improving. He recommended another right knee ultrasound with Dr. Crane. Dr. Paletta recommended Petitioner remain off work. (PX 7)

On May 16, 2018, Petitioner sought care at St. Louis Surgical Consultants with Dr. Thomas Niesen for groin and leg pain when sitting. He reported being diagnosed with an extensive DVT on April 17th and 20th. Dr. Niesen noted that Petitioner had surgery on his right knee in February. Dr. Niesen's assessment was: DVT of femoral vein of right lower extremity; increased BMI; DVT of popliteal vein of right lower extremity; and DVT of tibial vein of right lower extremity. Dr. Niesen opined it could take months for his clots to resolve or shrink. Dr. Niesen recommended a repeat exam and duplex scan to see how much recanalization or clot resolution is ongoing. (PX 15)

On June 11, 2018, Petitioner sought follow up care with Dr. Crane for another right knee ultrasound. His assessment was right knee pain, derangement of medial meniscus, osteoarthritis of knee, history of deep vein thrombosis, history of pulmonary embolus and pes anserinus bursitis. He opined Petitioner was a good candidate for BMAC/fat autograft on the right knee, but that he needed to have his DVT/PE under control for at least six months. (PX 14)

On June 22, 2018, Petitioner sought follow up care with Dr. Paletta. He reported gradual improvement with his right knee. Dr. Paletta found Petitioner to have overall stability in his meniscus. Dr. Paletta's impression was doing well. He recommended physical therapy. Petitioner was released back to light-duty. (PX 7)

On July 20, 2018, Petitioner sought follow up care with Dr. Fisher. She found him to still have DVT vomitus in his entire right leg. Dr. Fisher opined Petitioner will likely require long-term anticoagulation. (PX 12)

On August 22, 2018, Petitioner sought follow up care with Dr. Niesen. Dr. Niesen opined that his Duplex scan revealed continued deep venous thrombosis in the femoral and popliteal veins. He opined there has been no extension, but not a lot of resolution either. Dr. Niesen's impression was DVT of femoral vein of right lower extremity and DVT of popliteal vein of right lower extremity. Dr. Niesen recommended another six months of light duty work. (PX 15)

On August 27, 2018, Petitioner sought follow up care with Dr. Paletta six months post-surgery. Petitioner reported a recent episode of shortness of breath and chest pain after a recent therapy session. Petitioner continued to complain of knee, groin and calf pain. Dr. Paletta's impression was residual post thrombotic syndrome pain right lower extremity and mild residual medial joint line pain in the setting of the medial compartment DJD. Dr. Paletta found Petitioner's knee to look relatively good. Dr. Paletta opined he would defer to Dr. Niesen for treatment of his DVT. Petitioner was released back to light-duty. (PX 7)

On October 26, 2018, Petitioner sought follow care at St. Luke's Medical Group and Dr. Kristen Fisher for his PE. He reported continuing to have right leg pain and being unable to work. Dr. Fisher's diagnoses with pulmonary thromboembolism and deep venous thrombosis. He was to follow up for a recheck in six months. (PX 13)

On December 3, 2018, Petitioner sought follow up care with Dr. Paletta. He reported continuing to be seen by Dr. Neisen for his deep vein thrombosis. Dr. Paletta noted that he was not a candidate for a thrombectomy. Dr. Paletta's impression was post thrombosis pain status post deep vein thrombosis following right knee arthroscopy and doing well status post partial meniscectomy and repair of the meniscotibial ligaments. Dr. Paletta recommended additional physical therapy. Dr. Paletta continued Petitioner's work restrictions. (PX 7)

Petitioner underwent a right knee MRI Arthrogram at MRI Partners of Chesterfield on January 25, 2019. The radiologist's impression was: (1) complex nondisplaced tear throughout the body and posterior horn of the medial meniscus. There may be post-surgical changes involving the posterior horn of the medial meniscus possibly related to prior medial meniscus repair; (2) no acute ligament injury; (3) mild medial compartment osteophytosis; and (4) there is a small focus of grade IV chondrosis involving the superior patellar apex. (PX 6)

On March 4, 2019, Petitioner sought follow up care with Dr. Niesen. Petitioner underwent a right lower extremity venous duplex exam. Dr. Niesen's impression was partially occlusive chronic deep vein thrombosis of the right proximal femoral, distal femoral and distal popliteal veins. No evidence of chronic venous insufficiency of the right lower extremity. (PX 15)

Petitioner sought follow up care with Dr. Paletta on March 13, 2019. He reported having ongoing pain in the medial aspect of his knee and up to his thigh. Dr. Paletta's impression was medial compartment DJD and possible recurrent medial meniscus tear without evidence of failure of the root repair. Dr. Paletta opined Petitioner should consider a right total knee arthroplasty. He opined that Petitioner would need to be closely seen by Dr. Niesen before any surgery due to his history of deep vein thrombosis. Dr. Paletta referred Petitioner to Dr. Ryan Nunley at Washington University for evaluation for a right total knee arthroplasty. (PX 7)

Petitioner underwent an IME with Dr. Lynne Barkmeier on April 16, 2019. Dr. Barkmeier diagnosed right leg chronic venous insufficiency secondary to deep vein thrombosis. She opined that Petitioner's diagnosis was causally related to his June 22, 2017, work injury and subsequent surgery. Dr. Barkmeier recommended continued conservative treatment for the venous

insufficiency consisting of intermittent leg elevation three times a day for ten minutes, use of graduated stocking support and consistent extremity exercise with support in place. (RX 4; Ex. 2)

Petitioner underwent an IME with Dr. Joseph Ritchie of Orthopedic Specialists on May 21, 2019. Dr. Ritchie's diagnosis was a degenerative right knee with post-phlebitic syndrome of his right calf due to DVT. Dr. Ritchie opined that Petitioner may have sustained a right knee meniscus tear as a result of his June 22, 2017, accident that was subsequently treated. He opined that all of Petitioner's current problems are related to his degenerative arthritis. He agreed with Petitioner being evaluated for a right total knee replacement but opined that the need for one would not be related to his work injuries but, rather, his degenerative arthritis that predated his knee injury. Dr. Ritchie opined that Petitioner was at MMI and any work restrictions would be related to his DVT and arthritis. (RX 3; Ex. 2)

Dr. Ritchie authored an addendum report on July 31, 2019. He opined that any restrictions Petitioner may require would be due to his right knee arthritis and not any work-related injury. He agreed with Dr. Barkmeier's work restrictions for Petitioner to elevate his right leg for ten minutes three times a day. (RX 3; Ex. 3)

On August 22, 2019, Dr. Paletta authored a narrative report after viewing the IME report of Dr. Ritchie. He opined that Petitioner's residual symptoms are due to his deep vein thrombosis and postphlebitic syndrome of his right lower extremity. Dr. Paletta opined that he agreed with Dr. Ritchie's opinions that any right knee symptoms at this point are related to his underlying osteoarthritis. Dr. Paletta recommended Petitioner consider a right total knee replacement. Dr. Paletta opined that the total knee replacement would be related to the underlying degenerative osteoarthritis of the knee. He opined that both Dr. Ritchie and he believe that this is a preexisting condition. (PX 7)

On September 16, 2019, Petitioner sought follow up care with Dr. Niesen. He continued to complain of right knee pain and reported he was waiting for a knee replacement. Dr. Niesen's assessment was DVT of femoral vein of right lower extremity. He recommended continuing his anticoagulations indefinitely. (PX 15)

Dr. Paletta testified via evidence deposition on October 30, 2019. He is a board-certified orthopedic surgeon. He testified to his initial care and treatment of Petitioner. He testified he performed a right knee arthroscopy on February 20, 2018. The surgery consisted of debridement of the arthritis in his kneecap, meniscus repair, root repair and meniscotibial ligament repair. Dr. Paletta testified that Petitioner had lost less than 10 or 15 percent of his meniscus as a result of his procedure. He testified that Petitioner's meniscus tear and need for surgery was causally related to his work injury. Dr. Paletta testified that Petitioner's right knee was doing well at his follow up evaluations on August 27, 2018, and December 3, 2018. He opined that Petitioner's right knee complaints on December 3, 2018, were typical for early arthritic pain and not due to his meniscus. Dr. Paletta opined that Petitioner's ongoing right knee symptoms were related to his arthritic changes in his right knee. (PX 8)

On cross-examination, Dr. Paletta testified that he first saw Petitioner in July 2017 and diagnosed Petitioner with an acute meniscus tear but no aggravation of his underlying arthritis. He testified that following his surgery he found Petitioner to be improving in regard to his meniscus in August 2018 and December 2018. He testified that in March 2019 he found Petitioner's right knee pain to be related to his arthritis and not his meniscus. Dr. Paletta testified that Petitioner had underlying arthritis prior to his work injuries. He testified that he has never diagnosed any worsening or aggravation of his underlying arthritis as a result of his work injuries. (PX 8)

Dr. Ritchie testified via evidence deposition on November 20, 2019. Dr. Ritchie is a board-certified orthopedic surgeon. Dr. Ritchie testified he found Petitioner to have quite significant degenerative arthritis in his right knee and chronic calf pain likely post-phlebitis in nature. Dr. Ritchie testified that Petitioner's current condition in his right knee and leg was no longer related to either of his work accidents. He testified that Petitioner's current right knee and leg complaints are due to his longstanding osteoarthritis. He testified Petitioner has likely had arthritis for five or more years. Dr. Ritchie testified that Petitioner's arthritis is not related to his work injuries. Dr. Ritchie opined that Petitioner did not nee any further care or treatment for his right knee as a result of his work accidents. He testified that Petitioner did not require any work restrictions for his knee, and that any work restrictions would be due to his blood clot issues. (RX 3)

On cross-examination, Dr. Ritchie testified that Petitioner underwent an open right knee procedure with Dr. Paletta, but that an open procedure would not result in any more arthritis in the future. Dr. Ritchie testified that a right total knee replacement would be a reasonable treatment option. (RX 3)

Dr. Barkmeier testified via evidence deposition on December 19, 2019. Dr. Barkmeier is a board-certified vascular surgeon. She testified that Petitioner had a deep vein blood clot in his right leg below the groin following his February 2018 right knee surgery. She testified that Petitioner's work accident and subsequent surgery caused his blood clot. She testified that Petitioner should use a graduated stocking support, elevate his right leg and exercise his leg muscles.

On cross-examination, Dr. Barkmeier testified that Petitioner should continue to lift his right leg three or four times a day for the remainder of his life. She testified that Petitioner would be much more comfortable and productive if he followed her recommendation to lift his leg three times a day for ten minutes throughout the day, but the only side effects if he did not would likely be uncomfortable swelling at the end of the day. (RX 4)

CONCLUSIONS OF LAW:

In support of the Arbitrator's Decision relating to (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

There is no dispute that Petitioner sustained accidents that arose out of and in the course of his employment by Respondent on August 25, 2016, and June 22, 2017. There is no dispute that Petitioner suffered injuries to his right knee and right gastrocnemius as a result of his work injuries. There is also no dispute that Petitioner's February 20, 2018, right knee surgery is causally related to his June 22, 2017, work accident, as well as all treatment from August 25, 2016, through July 31, 2019. The parties agree that Petitioner's right leg blood clot is causally related to his June 22, 2017, work accident. The parties' dispute is whether Petitioner's condition of ill-being after July 31, 2019, in regard to his right knee osteoarthritis and need of an evaluation for a total knee replacement is causally related to his work accidents.

In Illinois, the petitioner bears the burden of proof in establishing that the medical treatment is causally related to the accident. *See: City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258 (1st Dist. 2011). In this case, Petitioner failed to prove by a preponderance of the evidence that his right knee arthritis is causally related to his August 25, 2016, and June 22, 2017, work accidents. The Arbitrator bases his finding on the more credible, reliable and persuasive opinions of Dr. Ritchie than those of Dr. Paletta.

When reviewing the records and expert testimony, Dr. Paletta agrees with the majority of Dr. Ritchie's opinions, and all of them in regard to the right knee osteoarthritis. In his August 22, 2019, office note, Dr. Paletta opined, "it appears Dr. Ritchie and I agree that any knee symptoms at this point are related to his underlying osteoarthritis." (PX 7, page 2) Dr. Paletta further states, "the need for total knee replacement would be related to the underlying degenerative osteoarthritis of the knee. Both Dr. Ritchie and I agree that this is a preexisting condition." (PX 7, page 2)

Dr. Paletta also testified that Petitioner had underlying arthritis prior to his work injuries. (PX 8, pages 7 & 26) Dr. Paletta testified that he has never diagnosed any worsening or aggravation of his underlying arthritis as a result of his work injuries. (PX 8, page 26) He testified that Petitioner had good healing of his meniscus. (PX 8, page 27) He testified that Petitioner had only lost 10% or 15% of his meniscus after his prior right knee surgery many years ago and the one he performed on February 20, 2018. (PX 8, page 9) Dr. Paletta testified that Petitioner's right knee looked good in August and December 2018, and he had good range of motion and stability. (PX 8, pages 24-25)

Dr. Ritchie testified that Petitioner's current condition in his right knee and leg was no longer related to either of his work accidents. (RX 3, page 9) He testified that Petitioner's arthritis is not related to his work injuries. (RX 3, page 9) Dr. Ritchie testified that Petitioner's current right knee and leg complaints are due to his longstanding osteoarthritis. (RX 3, page 10) He testified Petitioner has likely had arthritis for five or more years. (RX 3, page 11)

Dr. Barkmeier testified Petitioner had a deep vein blood clot in his right leg below the groin following his February 2018 right knee surgery. (RX 4, page 7-8) She testified that Petitioner's work accident and subsequent surgery caused his blood clot. (RX 4, page 8) She testified that Petitioner should use a graduated stocking support, elevate his right leg and exercise his leg muscles to improve the venous return. (RX 8, page 8) She did not have any other treatment recommendations. (RX 8, page 8) There were no contrary testimony offered by Petitioner regarding his right leg blood clots.

Based on the foregoing, as well as the credible evidence introduced at trial, and having found Dr. Ritchie's opinions to be more credible, reliable and persuasive, the Arbitrator finds that Petitioner's knee condition is at MMI. However, the Arbitrator finds the Petitioner's DVT sequelae is not at MMI and may require accommodations or treatment. The Petitioner failed to prove that his current condition of ill-being in his right knee in regard to his osteoarthritis and recommendation for an evaluation for a total knee replacement is causally related to his August 25, 2016, or June 22, 2017, work accidents.

In support of the Arbitrator's Decision relating to (J), Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Based on the parties' stipulation on the Arbitrator's Exhibit 1 and Respondent accepting liability for related medical expenses prior to July 31, 2019, the Arbitrator awards all the medical expenses in P X 16 totaling: $18,218.24 subject to the fee schedule

In support of the Arbitrator's Decision relating to (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Based on the Arbitrator's findings in regard to disputed issue (F) and having found that both Dr. Paletta and Dr. Ritchie opined that Petitioner had underlying arthritis prior to his work

injuries and did not sustain any worsening or aggravation of his underlying arthritis as a result of his work injuries, Petitioner's petition for prospective medical care for his right knee is denied. Note, the Arbitrator is not denying possible treatment for his right leg DVT sequelae.

In support of the Arbitrator's Decision relating to (L), Is Petitioner entitled to TTD, the Arbitrator finds and concludes as follows:

As of October 30, 2019, the date of Dr. Paletta's Deposition, he had the Peitioner on light duty with no squatting, no kneeling, no climbing, and lifting restrictions of 25 pounds. PX #8, pp. 20, line 19.

As of August 22, 2019 Drs. Paletta and Richie "agree that at this point the the Petitioner"s residual symptoms are due to DVT and postphebitic syndrome of his right lower extremity." PX 7, pp 1.

Dr. Barkmeier opined Petitioner was not at MMI and recommended leg elevation 3 to 4 times a day. Deposition, RX 4, pp.12 and Deposition Exh. 3 pp.1

Petitioner's restrictions were accommodated up to September 3, 2019. Arb.Trans. pp.23. On that date the Petitioner appeared for work and was sent home. The Arbitrator finds the Respondent either did not accommodate the Petitioner's restrictions or Petitioner was unable to do his job due to his DVT condition which both Drs. Paletta and Richie opined was his current residual symptom. Id.

Therefore, the Arbitrator awards Petitioner TTD from 9/4/19 through 1/24/20

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC019312
Case Name	STARK, RANDY v. USF HOLLAND
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0400
Number of Pages of Decision	21
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Julie Pagano

DATE FILED: 8/5/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0400

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randy Stark,

Petitioner,

vs. NO: 17 WC 19312

USF Holland,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by both parties herein and notice given to all parties, the Commission, after considering causal connection, medical expenses, prospective medical treatment, and temporary total disability ("TTD") benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission modifies the temporary total disability benefits awarded by the Arbitrator. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Facts

On July 3, 2017, Petitioner filed an Application for Adjustment of Claim in case 17 WC 19146 alleging a date of accident of August 25, 2016. That same day, Petitioner also filed an Application for Adjustment of Claim in case 17 WC 19312 alleging a date of accident of June 22, 2017. The cases were consolidated and both cases proceeded to hearing on January 24, 2020. The parties executed a single Request for Hearing form that addressed both cases. The Arbitrator filed a single Decision that addressed any pending issues in both cases. The Commission has issued a separate Decision in case 17 WC 19146.

The parties stipulated that Petitioner's current condition of ill-being and continued medical treatment relating to Petitioner's development of extensive deep vein thrombosis ("DVT") and pulmonary emboli are not in dispute. Respondent does not dispute that most Petitioner's ongoing complaints regarding his right leg are residual symptoms of the chronic DVT he developed. This present matter concerns the causal connection and medical treatment solely relating to Petitioner's ongoing right knee complaints. Respondent stipulated that Petitioner's right knee condition

remained causally related to the work accidents through July 31, 2019. Respondent also does not dispute the causal connection and reasonableness and necessity of medical treatment Petitioner underwent relating to the right knee through July 31, 2019.

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. Petitioner sustained a work-related injury to his right calf on August 25, 2016. Following that work accident, Petitioner returned to work without restrictions in April 2017. On June 22, 2017, he sustained a second work-related injury to his right calf and his right knee. Dr. Paletta, Petitioner's treating physician, diagnosed Petitioner with a chronic right medial gastrocnemius strain and a right medial meniscus tear. A June 2017 MRI of the right knee had the following impression: 1) radial tear near the inner margin root attachment posterior horn medial meniscus with nonspecific linear intrasubstance signal extending from the anterior horn through the body into the posterior horn; and 2) patellofemoral chondromalacia with mild joint effusion with no loose body formation and distal semimembranosus insertional tendinitis/tendinopathy with small adjacent developing Baker's cyst. On February 20, 2018, Petitioner underwent right knee surgery that included the following procedures: 1) arthroscopy with debridement of chondroplasty, medial tibiofemoral compartment; 2) debridement of chondroplasty, patellofemoral compartment; 3) repair of medial meniscus root avulsion; and 4) open medial meniscotibial ligament repair. The postoperative diagnoses were right knee pain with tibial ligament insufficiency, posterior horn medial meniscus root avulsion tear, medial compartment early degenerative joint disease, and patellofemoral chondromalacia.

Unfortunately, Petitioner's postsurgical recovery was significantly complicated by his development of an extensive acute DVT in the right leg and pulmonary emboli in April 2018. Petitioner continues to suffer from the residual effects of the DVT and pulmonary emboli and continues to see a vascular surgeon for these conditions. In December 2018, Petitioner complained of mild discomfort in his knee to Dr. Paletta. The doctor wrote that he was unsurprised by Petitioner's continued mild right knee pain due to Petitioner's medial compartment degenerative joint disease in the knee.

A January 2019 MRI of the right knee had the following impression: 1) complex nondisplaced tear throughout the body and posterior horn of the medial meniscus with possible postsurgical changes involving the posterior horn of the medial meniscus possibly related to the prior medial meniscus repair; 2) no acute ligament injury; 3) mild medial compartmental osteophytosis; and 4) small focus of grade IV chondrosis involving the superior patellar apex. Dr. Paletta last examined Petitioner on March 13, 2019. At that time, Petitioner continued to complain of increasing right knee pain as well as significant symptoms relating to his DVT diagnosis. After reviewing the recent right knee MRI, Dr. Paletta determined there was clear medial compartment narrowing with progressive degenerative changes and progressive degenerative changes of the patellofemoral joint. He recommended Petitioner undergo a right total right knee replacement to address Petitioner's ongoing right knee complaints. Dr. Patella referred Petitioner to Dr. Nunley for a consultation regarding a possible knee replacement surgery. Petitioner has continued to receive chiropractic treatment and physical therapy from the medical practice of Dr. Eavenson, Petitioner's treating chiropractor.

Petitioner testified that he continues to experience pain and swelling in his right leg and

now walks with a cane. He testified that he feels immense pain in his right knee while walking and must take care, so the knee does not give out. Petitioner testified that he wants to pursue the consultation with Dr. Nunley regarding a possible right knee replacement. He testified that his right knee pain can rate as high as 9/10.

Petitioner testified that he underwent a right knee surgery approximately 27 years earlier. He denied having any problems with the knee when he began working for Respondent and passed the required Department of Transportation physical. Petitioner denied missing any work before these injuries due to any problems with his right knee. He admitted that he was diagnosed with right knee arthritis before either of these work injuries.

Dr. Paletta opined both in a narrative report he prepared at the request of Petitioner's counsel and during his evidence deposition that any knee symptoms Petitioner currently experiences relate to Petitioner's underlying degenerative osteoarthritis. Dr. Paletta further opined that the need for a total right knee replacement relates to the preexisting osteoarthritis. Dr. Paletta testified that the January 2019 right knee MRI revealed that Petitioner was down to bone-on-bone in the knee. He testified that in December 2018, he determined Petitioner's residual knee symptoms related to the underlying arthritis.

Dr. Ritchie examined Petitioner pursuant to Section 12 of the Act on May 21, 2019, at the request of Respondent. He prepared a written report and testified via evidence deposition. After examining Petitioner and reviewing medical records, he opined that Petitioner's ongoing right knee complaints relate to the continued degenerative changes in the knee. He opined that Petitioner's complaints and the possible necessity of a right knee replacement are not related to either work accident. Dr. Ritchie opined Petitioner had reached maximum medical improvement ("MMI") for the right knee regarding the work accidents and any work restrictions would relate to either Petitioner's DVT condition and/or his degenerative arthritis.

Dr. Barkmeier examined Petitioner pursuant to Section 12 of the Act on April 16, 2019, at the request of Respondent. The doctor prepared a written report and testified via evidence deposition. Dr. Barkmeier diagnosed Petitioner with right leg chronic venous insufficiency secondary to deep vein thrombosis as a sequela of the acute DVT. She opined that Petitioner did not require any work restrictions due to his chronic venous insufficiency. However, she opined that Petitioner would need to elevate his leg during work and lunch breaks three times for ten minutes each time during the workday. Dr. Barkmeier testified that Petitioner would be able to perform his regular work duties. The doctor further testified that Petitioner would be able to return to full duty work in his normal position even if Respondent could not accommodate her recommendation regarding Petitioner's need to elevate his leg during the workday. Dr. Barkmeier testified that Petitioner would be more comfortable if he were able to elevate his leg as recommended; however, she has plenty patients who are not able to follow this recommendation. Patients who are unable to follow her recommendation regarding elevating the leg during the workday may experience uncomfortable swelling particularly at the end of the day.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the

evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). When a claimant suffers from a preexisting condition, the claimant must show that a work-related accidental injury aggravated or accelerated the preexisting condition "…such that the [claimant's] current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *Id*. at 204.

After carefully considering the evidence, the Commission affirms the Arbitrator's conclusion that Petitioner failed to meet his burden of proving his current condition of ill-being regarding his right knee is causally related to either work accident. The Commission also affirms the Arbitrator's denial of prospective medical care in the form of an evaluation by Dr. Nunley. There is ample evidence supporting the conclusion that the current condition of Petitioner's right knee is not causally related to the work injuries. This includes the medical records and opinions of Petitioner's treating physician, Dr. Paletta. Dr. Paletta notably opined that Petitioner's ongoing right knee complaints no longer relate to the work injuries; instead, Petitioner's complaints now relate to the preexisting degenerative arthritis in that knee. Furthermore, Dr. Paletta opined that Petitioner's potential need of a right knee replacement also relates to the preexisting arthritis. Dr. Ritchie, Respondent's Section 12 Examiner, agrees with these opinions. Finally, the Commission affirms the Arbitrator's conclusion that any causal connection of Petitioner's right knee condition to the work accidents ceased after July 31, 2019.

After reviewing the evidence, the Commission must modify the Arbitrator's award of TTD benefits for the period of September 4, 2019, through January 24, 2020, for a total of 20-3/7 weeks. Petitioner sought TTD for the periods of June 23, 2017, through July 16, 2017, February 25, 2018, through April 4, 2018, and September 4, 2019, through January 24, 2020, for a total of 29-3/7 weeks. The parties stipulated that Respondent owes TTD benefits for the period of February 25, 2018, through April 4, 2018.

The Commission finds that Petitioner has failed to prove an entitlement to TTD benefits for the periods of June 23, 2017, through June 25, 2017, and September 4, 2019, through January 24, 2020. Respondent sustained his second work injury on June 22, 2017; however, he did not seek medical treatment until June 26, 2017. On that date, the doctor took Petitioner off work due to his injury. There is no evidence that any medical provider prescribed any work restrictions relating to this second work accident before June 26, 2017. Thus, the Commission finds Petitioner's entitlement to TTD began on June 26, 2017. An examination of the payment ledger submitted by Respondent reveals that it has already paid TTD for the period of June 26, 2017, through June 29, 2017. (RX 1). Therefore, Respondent is liable for TTD benefits for the period of June 30, 2017, through July 16, 2017, or 2-3/7 weeks.

Due to the Commission's finding that Petitioner's current condition of ill-being regarding his right knee is not causally related to either work accident, the Commission must vacate the Arbitrator's award of TTD benefits from September 4, 2019, through January 24, 2020. Petitioner's right knee condition was causally related to the work injuries only through July 31, 2019. Thus, Petitioner is only entitled to TTD benefits after that date if the evidence reveals a doctor has restricted Petitioner from work due to his ongoing issues relating to his chronic DVT condition. The Arbitrator awarded TTD from September 4, 2019, through January 24, 2020, due to Petitioner's residual symptoms relating to the DVT and subsequent postphlebitic syndrome of

the right leg. While the Commission agrees that Petitioner continues to suffer significant residual symptoms due to his DVT condition, the Commission finds there is no evidence that any doctor has prescribed work restrictions due to the chronic DVT symptoms from September 4, 2019, through January 24, 2020. Additionally, Dr. Barkmeier, Respondent's Section 12 Examiner, opined that Petitioner is able return to his normal job without restrictions despite his ongoing symptoms relating the chronic venous insufficiency. Dr. Barkmeier credibly testified that Petitioner should take time to elevate his leg three times during the workday for 10 minutes each time. She further testified that Petitioner could return to work full duty even if Respondent is unable to accommodate her recommendation that Petitioner elevate his leg three times during the workday. There is no evidence that contradicts this opinion. Therefore, the Commission finds Respondent is liable for TTD benefits for the periods of June 30, 2017, through July 16, 2017, and February 25, 2018, and April 4, 2018, for a total of eight weeks.

Finally, the Commission corrects a clerical error in the Decision of the Arbitrator. On the Arbitration Decision Form, the Arbitrator wrote the arbitration hearing occurred on 01/20/2020. This is clearly a scrivener's error. The Commission thus modifies the above-referenced sentence to read as follows:

> The matter was heard by the Honorable Edward Lee, Arbitrator of the Commission, in the city of Collinsville, IL on 01/2**4**/2020.

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 March 25, 2020, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his right knee is not causally related to either the August 25, 2016, or June 22, 2017, work accidents. The Commission finds Petitioner's current condition of ill-being relating to his chronic DVT condition is causally related to the June 22, 2017, work accident.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $683.02/week for 8 weeks, commencing June 30, 2017, through July16, 2017, and February 25, 2018, through April 4, 2018, as provided in Section 8(b) of the Act. Respondent shall be given a credit for all temporary total disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges, as provided in Sections 8(a) and 8.2 of the Act. Respondent is not liable for any expenses for medical treatment provided after July 31, 2019, relating to Petitioner's right knee.

IT IS FURTHER ORDERED that prospective medical treatment in the form of the evaluation by Dr. Nunley at Washington University in St. Louis recommended by Dr. Paletta is

hereby denied.

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

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

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

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.

August 5, 2021

o: 6/8/21
TJT/jds
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 21IWCC0400
NOTICE OF 19(b) ARBITRATOR DECISION

STARK, RANDY
Employee/Petitioner

Case# **17WC019146**
17WC019312

USF HOLLAND
Employer/Respondent

On 3/25/2020, 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 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

2904 HENNESSY & ROACH PC
PAUL N BERARD
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

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)

RANDY STARK
Employee/Petitioner

v.

USF HOLLAND
Employer/Respondent

Case # **17** WC **19146**

Consolidated cases: **17 WC 19312**

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, IL** on **01/20/2020**. 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 accidents, **08/25/2016 and 06/22/2017**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**52,275.73**; the average weekly wage was $**1,024.53**.

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 $**all TTD paid** for all TPD paid.

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

ORDER

Petitioner proved that his current condition of DVT sequelae in his right leg is causally related to his work injury.

Respondent shall pay reasonable and necessary medical services pursuant to the Medical Fee Schedule set forth in Petitioner's Exhibit 16.

Respondent shall pay Petitioner temporary total disability benefits of $683.02 for 20 3/7 weeks commencing September 4, 2019 to January 24, 2020 , as provided in Section 8(b) of the Act.

Petitioner's claim for prospective medical consisting of an evaluation with Dr. Nunley at Washington University is hereby denied.

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

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

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

Carl Lee — Signature of Arbitrator

3/19/20 — Date

ICArbDec19(b)

MAR 25 2020

FINDINGS OF FACT:

These claims were tried pursuant to Petitioner's Request for Hearing under Section 19(b) of the Act. The parties stipulated to both claims being consolidated at the time of hearing. The parties also stipulated that Petitioner sustained accidents that arose out of and in the course of his employment by Respondent. However, Respondent disputed that Petitioner's current condition of ill-being was causally related to his accidents, as well as its liability for medical expenses after July 31, 2019, and 29 3/7 weeks of TTD for various times periods indicated on Arbitrator's Exhibit 1. Petitioner is also seeking an award of prospective medical treatment consisting of an evaluation for a right total knee replacement with Dr. Nunley at Washington University.

Petitioner, a 55-year-old local delivery driver, sustained an accidental injury to his right calf on August 25, 2016. He testified that he was making a delivery of roll stock paper to a printing plan up on the Hill in St. Louis. (TR-13) As he was pulling the stock of paper down the sidewalk into the building, he felt something pull in his right calf. (TR-13) He testified he sought medical treatment and physical therapy until returning to work on April 20, 2017. (TR-14) He testified he was paid workers' compensation from the date of his injury through his return to work. (TR-14-15)

Petitioner testified that he had returned to full duty work with some occasional fatigue and soreness in his right calf towards the end of the days. (TR-15) He testified that on June 22, 2017, he was delivering a 700 or 900-pound skid of books to a school district in Arnold, and as he was pulling the pallet jack he felt his right knee pop and reinjured his right calf. (TR-15-16) He went to Gateway Occupational. (TR-15) He testified he had previously had a right knee surgery 27 years ago. (TR-16) Petitioner denied having any problems with his right knee prior to his employment at Respondent. (TR-17)

Petitioner testified he underwent right knee surgery on February 20, 2018. (TR-17) He was being paid workers' compensation at the time. (TR-18) He testified he developed blood clots in his right leg shortly after surgery. (TR-18) He was hospitalized twice and underwent treatment with several physicians. (TR-18-19) He is currently only seeing Dr. Fisher for follow up of his blood clots. (TR-19) Petitioner testified he currently has right knee pain and wants to be evaluated by Dr. Nunley at Washington University at the referral of Dr. Paletta for consideration of a right total knee replacement. (TR-22-23)

On cross-examination, Petitioner testified that he lived 28 miles from Respondent's terminal. (TR-24-25) He testified he was unable to drive his car to work light duty at Respondent in February and March 2018 because he had to wear a full leg brace. (TR-25) (TR-25-26) He testified that Respondent requested he return to his regular job on September 4, 2019. He testified that he was diagnosed with arthritis in his knee prior to either of his work injuries. (TR-27)

On August 25, 2016, Petitioner presented to Gateway Regional Medical Center ER after initially being evaluated at Gateway Reginal Occupational Health Services, Inc. He reported feeling something pop in his right lower leg while he was at work pulling a 900-pound object. Right knee x-rays revealed minimal degenerative osteoarthritis. Petitioner was diagnosed with a right calf strain and possible muscle tear. (PX 1 and PX 2)

On August 27, 2016, Petitioner sought care at BJC Medical Group Orthopedics and Sports Medicine for right calf pain. He was diagnosed with a right gastrocnemius muscle strain. He was taken off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on September 9, 2016. Physical therapy was prescribed and Petitioner was continued off work. (PX 3)

Petitioner presented for an initial therapy evaluation at Fyzical Therapy and Balance Centers on September 13, 2016. He completed 86 physical therapy sessions for his right calf through April 13, 2017. (PX 4)

On September 23, 2016, Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain. A right calf MRI was prescribed. Petitioner was released to work without restrictions on October 7, 2016. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on October 7, 2016. A right calf MRI revealed a partial grade 2 tear of his right gastrocnemius. Additional physical therapy was prescribed, and Petitioner was taken off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on November 4, 2016. He reported making significant improvement with therapy. Additional physical therapy was prescribed, and Petitioner was continued off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on December 2, 2016. He continued to improve but was still reporting difficult with walking more than 30 minutes. Additional physical therapy was prescribed, and Petitioner was continued off work. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on January 3, 2017. Petitioner was released to light office work with occasional walking or standing, occasional lifting up to 10 pounds and/or carrying articles like small clothes. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on January 27, 2017. He reported making significant improvements with his right gastric. He was able to walk 1.5 miles without pain. He was still unsure about being able to push and pull significant amounts of heavy weights. He did not think he was quite ready to return to work. His light duty restrictions were continued. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on February 17, 2017. He reported still being unable to pull up to 900 pounds, as he has only done 130 pounds in therapy. His light duty restrictions were continued. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on March 20, 2017. He reported now pulling up to 200 pounds in therapy. He requested additional therapy. His light duty restrictions were continued. (PX 3)

Petitioner sought follow up care at BJC Medical Group Orthopedics and Sports Medicine for his right gastrocnemius strain on April 17, 2017. He reported doing well since his last visit and feeling ready to return to work without restrictions. Petitioner was released to full duty on this day and discharged from care. (PX 3)

Petitioner began working his regular job duties again on April 20, 2017. Petitioner continued to work his regular job duties in May and June 2017. On June 22, 2017, he sustained another right knee and leg injury while delivering a 700 or 900-pound skid of books to a school district in Arnold. (TR-15-16)

On June 26, 2017, Petitioner presented to Multicare Specialists, PC, for right medial calf pain and posterior knee pain. Petitioner reported that a few days prior he was climbing into his truck and felt a pop in his right calf. Dr. Eavenson diagnosed a right medial gastrocnemius recurrent tear of the right knee. (PX 5)

Petitioner was evaluated at Gateway Regional Occupational Health Services, Inc. on June 26, 2017, as well. He reported a consistent history of sustaining a right calf injury on June 22, 2017. Petitioner was diagnosed with a right calf strain and swelling. MRIs of the right knee and right calf were prescribed. Petitioner was taken off work until one day after he undergoes the MRIs. (PX 1)

On June 27, 2017, Petitioner underwent a right calf MRI at MRI Partners of Chesterfield. The radiologist's impression was: (1) area of fatty replacement within the medial head of the gastrocnemius lipoma or from previous injury or denervation without evidence of tear; (2) small joint effusion and small Baker's cyst; (3) varicose veins; and (4) no evidence of stress reaction or stress fracture. (PX 6)

On June 28, 2017, Petitioner underwent a right knee MRI at MRI Partners of Chesterfield. The radiologist's impression was: (1) radial tear near the inner margin root attachment posterior horn medial meniscus with nonspecific linear intrasubstance signal extending from the anterior horn through the body into the posterior horn accompanying the aforementioned; (2) patellofemoral chondromalacia with mild joint effusion but no loose body formation; and (3) distal semimembranosus insertional tendinitis/tendinopathy with small adjacent developing Baker's cyst. (PX 6)

Petitioner underwent physical therapy and chiropractic care at Multicare Specalists from June 27, 2017, through January 21, 2020. Petitioner attended over 350 physical therapy and chiropractic sessions during this time. The total billed amount for this physical therapy and chiropractic treatment was in excess of $150,000.00. Respondent paid more than $86,000.00 for this physical therapy and chiropractic treatment. (PX 5 & 16)

On July 14, 2017, Petitioner presented to Dr. George Paletta, Jr. at The Orthopedic Center of St. Louis for right knee and right calf pain. He reported having a history of a right calf injury one year prior while moving a 900-pound pallet. Petitioner reported being reinjured on 6-22-17 when using a pallet jack to move a 700-pound pallet. He reported initially going back to work and his pain being worse each day. Dr. Paletta noted that Petitioner's primary complaints were in the medial gastroc. Dr. Paletta reviewed Petitioner's MRIs. Dr. Paletta's impression was (1) chronic medial gastroc strain with probable fatty infiltration versus intramuscular denervation and (2) early osteoarthritis in the right knee associated with radial tear of medial meniscus. Dr. Paletta recommended a right knee injection and EMG of the calf. Dr. Paletta opined Petitioner may need a right knee surgery. He recommended he continued with physical therapy. Petitioner was released with being able to bear weight as tolerated. (PX 7)

On November 2, 2017, Petitioner underwent an EMG at Neurological & Electrodiagnostic Institute, Inc. Dr. Phillips' impression was very mild distal diabetic type peripheral neuropathy. Study not impressive for additional right lower extremity traumatic neuropathy. (PX 9)

On November 8, 2017, Dr. Paletta authorized a report regarding Petitioner's recent EMG. Dr. Paletta opined that the testing demonstrated findings consistent with a mild distal diabetic type peripheral neuropathy. Dr. Paletta's impression was mild diabetic peripheral neuropathy. Dr. Paletta opined that there is no evidence of any specific neurologic injury. Dr. Paletta recommended a repeat MRI to determine whether surgery would be needed for the calf. He opined Petitioner would also require a right knee arthroscopy and partial meniscectomy. Dr. Paletta opined he was reluctant to recommend any surgery on the knee given the degree of symptoms in the gastroc. (PX 7)

Petitioner underwent a right calf MRI at MRI Partners of Chesterfield on January 12, 2018. The radiologist's impression was intramuscular lipoma within the distal gastrocnemius medial head measuring up to 5.2 by 6.4 and 2.3 cm and numerous large saphenous venous varicosities. (PX 6)

On January 25, 2018, Petitioner sought follow up care with Dr. Paletta for continued right knee pain. Dr. Paletta's impression was persistently symptomatic radial tear of medial meniscus of right knee with associated early medial compartment DJD. He recommended Petitioner undergo a diagnostic ultrasound with Dr. David Crane to determine what surgery would be most beneficial. (PX 7)

On February 5, 2018, Dr. David Crane at Bluetail Medical Group performed a diagnostic ultrasound of the right knee. His assessment was right knee pain, derangement of medial meniscus, osteoarthritis and pes anserinus bursitis. He opined Petitioner was a good candidate for meniscal extrusion/medial capsule repair followed by BMAC/fat autograft to the right knee. (PX 14)

On February 20, 2018, Dr. Paletta performed a right knee intraoperative diagnostic ultrasonography, diagnostic arthroscopy, debridement of chondroplasty of medial tibiofemoral compartment, debridement of chondroplasty of patellofemoral compartment, repair of medial meniscus root avulsion and open medial meniscotibial ligament repair. (PX 8; Ex. 2)

On March 5, 2018, Petitioner sought follow up care with Dr. Paletta for initial post-op evaluation. He reported doing well overall. Petitioner was released to light-duty of no lifting or material handling, and no pushing/pulling. (PX 7)

Petitioner began physical therapy and chiropractic care for his right knee at Multicare Specialists on March 6, 2018. He continued with therapy on March 7th, 8th, 12th, 15th and 19th. (PX 5)

On April 4, 2018, Petitioner sought follow up care with Dr. Paletta seven-weeks post-surgery. He reported having continued knee pain with intermittent swelling. Dr. Paletta's impression was residual effusion of right knee and mild motion loss status post meniscus root repair and medial meniscotibial ligament repair. Dr. Paletta recommended Petitioner continue with physical therapy. He released Petitioner to light-duty of no standing or walking more than 15 minutes per hour, primarily sedentary work, no lifting/pushing/pulling/carrying/squatting/kneeling/ladders or climbing and limit stairs to one flight per hour. (PX 7)

On April 10, 2018, Petitioner sought care at Multicare Specialists for therapy and chiropractic care. He reported having an increase in swelling in the right lower extremity. Dr. Eavenson diagnosed Petitioner with acute DVT of the right lower extremity. (PX 5)

On April 10, 2018, Petitioner underwent a vascular doppler ultrasound at Gateway Regional Medical Center. Dr. Patel's conclusion was (1) acute DVT involving right CFV, SFV, DFV, Popliteal vein and PTV; and (2) normal left lower extremity venous scan. (PX 10)

Petitioner presented to St. Luke's Hospital ER for shortness of breath and chest pain on April 16, 2018. He reported being diagnosed with DVT a week ago and being on Eliquis twice daily since. He reported developing right sided chest pain and dyspnea that is worse with walking. Petitioner was diagnosed with a pulmonary embolism, right leg DVT, Type 2 diabetes, hypertension, and hypothyroidism. He was admitted to the hospital and eventually discharged on April 18th. (PX 13)

On April 20, 2018, Petitioner presented to St. Luke's Hospital ER for knee pain. He reported being released two days prior but having his 80-pound dog hit him in his right knee with his tail and he started having pain and swelling again. He reported barely being able to walk. Right knee x-rays did not reveal any fracture. A vascular report found Petitioner to have evidence of acute DVT on the right. Petitioner was diagnosed with a traumatic hematoma of the right knee and discharged from the ER. (PX 13)

On May 8, 2018, Petitioner presented to Dr. Kristen Fisher at Cardio Pulmonary Associates follow up care for PE/DVT. Dr. Fisher noted that Petitioner had knee surgery in February and had persistent swelling in his right leg. Dr. Fisher diagnosed pulmonary embolism with right DVT provoked by recent knee surgery. She recommended at least six months of anticoagulation. Dr. Fisher also diagnosed DVT. She opined he has an extensive clot. She was not sure whether much could be done but referred Petitioner to a vascular surgeon for further evaluation. (PX 12)

On May 11, 2018, Petitioner sought follow up care with Dr. Paletta. Dr. Paletta noted that his post-op course has been complicated by Petitioner's proximal deep vein thrombosis with pulmonary embolism. Petitioner reported that his right knee was gradually improving. He no longer had a sharp stabbing pain. Dr. Paletta opined that Petitioner's right knee is gradually improving. He recommended another right knee ultrasound with Dr. Crane. Dr. Paletta recommended Petitioner remain off work. (PX 7)

On May 16, 2018, Petitioner sought care at St. Louis Surgical Consultants with Dr. Thomas Niesen for groin and leg pain when sitting. He reported being diagnosed with an extensive DVT on April 17th and 20th. Dr. Niesen noted that Petitioner had surgery on his right knee in February. Dr. Niesen's assessment was: DVT of femoral vein of right lower extremity; increased BMI; DVT of popliteal vein of right lower extremity; and DVT of tibial vein of right lower extremity. Dr. Niesen opined it could take months for his clots to resolve or shrink. Dr. Niesen recommended a repeat exam and duplex scan to see how much recanalization or clot resolution is ongoing. (PX 15)

On June 11, 2018, Petitioner sought follow up care with Dr. Crane for another right knee ultrasound. His assessment was right knee pain, derangement of medial meniscus, osteoarthritis of knee, history of deep vein thrombosis, history of pulmonary embolus and pes anserinus bursitis. He opined Petitioner was a good candidate for BMAC/fat autograft on the right knee, but that he needed to have his DVT/PE under control for at least six months. (PX 14)

On June 22, 2018, Petitioner sought follow up care with Dr. Paletta. He reported gradual improvement with his right knee. Dr. Paletta found Petitioner to have overall stability in his meniscus. Dr. Paletta's impression was doing well. He recommended physical therapy. Petitioner was released back to light-duty. (PX 7)

On July 20, 2018, Petitioner sought follow up care with Dr. Fisher. She found him to still have DVT vomitus in his entire right leg. Dr. Fisher opined Petitioner will likely require long-term anticoagulation. (PX 12)

On August 22, 2018, Petitioner sought follow up care with Dr. Niesen. Dr. Niesen opined that his Duplex scan revealed continued deep venous thrombosis in the femoral and popliteal veins. He opined there has been no extension, but not a lot of resolution either. Dr. Niesen's impression was DVT of femoral vein of right lower extremity and DVT of popliteal vein of right lower extremity. Dr. Niesen recommended another six months of light duty work. (PX 15)

On August 27, 2018, Petitioner sought follow up care with Dr. Paletta six months post-surgery. Petitioner reported a recent episode of shortness of breath and chest pain after a recent therapy session. Petitioner continued to complain of knee, groin and calf pain. Dr. Paletta's impression was residual post thrombotic syndrome pain right lower extremity and mild residual medial joint line pain in the setting of the medial compartment DJD. Dr. Paletta found Petitioner's knee to look relatively good. Dr. Paletta opined he would defer to Dr. Niesen for treatment of his DVT. Petitioner was released back to light-duty. (PX 7)

On October 26, 2018, Petitioner sought follow care at St. Luke's Medical Group and Dr. Kristen Fisher for his PE. He reported continuing to have right leg pain and being unable to work. Dr. Fisher's diagnoses with pulmonary thromboembolism and deep venous thrombosis. He was to follow up for a recheck in six months. (PX 13)

On December 3, 2018, Petitioner sought follow up care with Dr. Paletta. He reported continuing to be seen by Dr. Neisen for his deep vein thrombosis. Dr. Paletta noted that he was not a candidate for a thrombectomy. Dr. Paletta's impression was post thrombosis pain status post deep vein thrombosis following right knee arthroscopy and doing well status post partial meniscectomy and repair of the meniscotibial ligaments. Dr. Paletta recommended additional physical therapy. Dr. Paletta continued Petitioner's work restrictions. (PX 7)

Petitioner underwent a right knee MRI Arthrogram at MRI Partners of Chesterfield on January 25, 2019. The radiologist's impression was: (1) complex nondisplaced tear throughout the body and posterior horn of the medial meniscus. There may be post-surgical changes involving the posterior horn of the medial meniscus possibly related to prior medial meniscus repair; (2) no acute ligament injury; (3) mild medial compartment osteophytosis; and (4) there is a small focus of grade IV chondrosis involving the superior patellar apex. (PX 6)

On March 4, 2019, Petitioner sought follow up care with Dr. Niesen. Petitioner underwent a right lower extremity venous duplex exam. Dr. Niesen's impression was partially occlusive chronic deep vein thrombosis of the right proximal femoral, distal femoral and distal popliteal veins. No evidence of chronic venous insufficiency of the right lower extremity. (PX 15)

Petitioner sought follow up care with Dr. Paletta on March 13, 2019. He reported having ongoing pain in the medial aspect of his knee and up to his thigh. Dr. Paletta's impression was medial compartment DJD and possible recurrent medial meniscus tear without evidence of failure of the root repair. Dr. Paletta opined Petitioner should consider a right total knee arthroplasty. He opined that Petitioner would need to be closely seen by Dr. Niesen before any surgery due to his history of deep vein thrombosis. Dr. Paletta referred Petitioner to Dr. Ryan Nunley at Washington University for evaluation for a right total knee arthroplasty. (PX 7)

Petitioner underwent an IME with Dr. Lynne Barkmeier on April 16, 2019. Dr. Barkmeier diagnosed right leg chronic venous insufficiency secondary to deep vein thrombosis. She opined that Petitioner's diagnosis was causally related to his June 22, 2017, work injury and subsequent surgery. Dr. Barkmeier recommended continued conservative treatment for the venous

insufficiency consisting of intermittent leg elevation three times a day for ten minutes, use of graduated stocking support and consistent extremity exercise with support in place. (RX 4; Ex. 2)

Petitioner underwent an IME with Dr. Joseph Ritchie of Orthopedic Specialists on May 21, 2019. Dr. Ritchie's diagnosis was a degenerative right knee with post-phlebitic syndrome of his right calf due to DVT. Dr. Ritchie opined that Petitioner may have sustained a right knee meniscus tear as a result of his June 22, 2017, accident that was subsequently treated. He opined that all of Petitioner's current problems are related to his degenerative arthritis. He agreed with Petitioner being evaluated for a right total knee replacement but opined that the need for one would not be related to his work injuries but, rather, his degenerative arthritis that predated his knee injury. Dr. Ritchie opined that Petitioner was at MMI and any work restrictions would be related to his DVT and arthritis. (RX 3; Ex. 2)

Dr. Ritchie authored an addendum report on July 31, 2019. He opined that any restrictions Petitioner may require would be due to his right knee arthritis and not any work-related injury. He agreed with Dr. Barkmeier's work restrictions for Petitioner to elevate his right leg for ten minutes three times a day. (RX 3; Ex. 3)

On August 22, 2019, Dr. Paletta authored a narrative report after viewing the IME report of Dr. Ritchie. He opined that Petitioner's residual symptoms are due to his deep vein thrombosis and postphlebitic syndrome of his right lower extremity. Dr. Paletta opined that he agreed with Dr. Ritchie's opinions that any right knee symptoms at this point are related to his underlying osteoarthritis. Dr. Paletta recommended Petitioner consider a right total knee replacement. Dr. Paletta opined that the total knee replacement would be related to the underlying degenerative osteoarthritis of the knee. He opined that both Dr. Ritchie and he believe that this is a preexisting condition. (PX 7)

On September 16, 2019, Petitioner sought follow up care with Dr. Niesen. He continued to complain of right knee pain and reported he was waiting for a knee replacement. Dr. Niesen's assessment was DVT of femoral vein of right lower extremity. He recommended continuing his anticoagulations indefinitely. (PX 15)

Dr. Paletta testified via evidence deposition on October 30, 2019. He is a board-certified orthopedic surgeon. He testified to his initial care and treatment of Petitioner. He testified he performed a right knee arthroscopy on February 20, 2018. The surgery consisted of debridement of the arthritis in his kneecap, meniscus repair, root repair and meniscotibial ligament repair. Dr. Paletta testified that Petitioner had lost less than 10 or 15 percent of his meniscus as a result of his procedure. He testified that Petitioner's meniscus tear and need for surgery was causally related to his work injury. Dr. Paletta testified that Petitioner's right knee was doing well at his follow up evaluations on August 27, 2018, and December 3, 2018. He opined that Petitioner's right knee complaints on December 3, 2018, were typical for early arthritic pain and not due to his meniscus. Dr. Paletta opined that Petitioner's ongoing right knee symptoms were related to his arthritic changes in his right knee. (PX 8)

On cross-examination, Dr. Paletta testified that he first saw Petitioner in July 2017 and diagnosed Petitioner with an acute meniscus tear but no aggravation of his underlying arthritis. He testified that following his surgery he found Petitioner to be improving in regard to his meniscus in August 2018 and December 2018. He testified that in March 2019 he found Petitioner's right knee pain to be related to his arthritis and not his meniscus. Dr. Paletta testified that Petitioner had underlying arthritis prior to his work injuries. He testified that he has never diagnosed any worsening or aggravation of his underlying arthritis as a result of his work injuries. (PX 8)

Dr. Ritchie testified via evidence deposition on November 20, 2019. Dr. Ritchie is a board-certified orthopedic surgeon. Dr. Ritchie testified he found Petitioner to have quite significant degenerative arthritis in his right knee and chronic calf pain likely post-phlebitis in nature. Dr. Ritchie testified that Petitioner's current condition in his right knee and leg was no longer related to either of his work accidents. He testified that Petitioner's current right knee and leg complaints are due to his longstanding osteoarthritis. He testified Petitioner has likely had arthritis for five or more years. Dr. Ritchie testified that Petitioner's arthritis is not related to his work injuries. Dr. Ritchie opined that Petitioner did not nee any further care or treatment for his right knee as a result of his work accidents. He testified that Petitioner did not require any work restrictions for his knee, and that any work restrictions would be due to his blood clot issues. (RX 3)

On cross-examination, Dr. Ritchie testified that Petitioner underwent an open right knee procedure with Dr. Paletta, but that an open procedure would not result in any more arthritis in the future. Dr. Ritchie testified that a right total knee replacement would be a reasonable treatment option. (RX 3)

Dr. Barkmeier testified via evidence deposition on December 19, 2019. Dr. Barkmeier is a board-certified vascular surgeon. She testified that Petitioner had a deep vein blood clot in his right leg below the groin following his February 2018 right knee surgery. She testified that Petitioner's work accident and subsequent surgery caused his blood clot. She testified that Petitioner should use a graduated stocking support, elevate his right leg and exercise his leg muscles.

On cross-examination, Dr. Barkmeier testified that Petitioner should continue to lift his right leg three or four times a day for the remainder of his life. She testified that Petitioner would be much more comfortable and productive if he followed her recommendation to lift his leg three times a day for ten minutes throughout the day, but the only side effects if he did not would likely be uncomfortable swelling at the end of the day. (RX 4)

CONCLUSIONS OF LAW:

In support of the Arbitrator's Decision relating to (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

There is no dispute that Petitioner sustained accidents that arose out of and in the course of his employment by Respondent on August 25, 2016, and June 22, 2017. There is no dispute that Petitioner suffered injuries to his right knee and right gastrocnemius as a result of his work injuries. There is also no dispute that Petitioner's February 20, 2018, right knee surgery is causally related to his June 22, 2017, work accident, as well as all treatment from August 25, 2016, through July 31, 2019. The parties agree that Petitioner's right leg blood clot is causally related to his June 22, 2017, work accident. The parties' dispute is whether Petitioner's condition of ill-being after July 31, 2019, in regard to his right knee osteoarthritis and need of an evaluation for a total knee replacement is causally related to his work accidents.

In Illinois, the petitioner bears the burden of proof in establishing that the medical treatment is causally related to the accident. *See: City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258 (1st Dist. 2011). In this case, Petitioner failed to prove by a preponderance of the evidence that his right knee arthritis is causally related to his August 25, 2016, and June 22, 2017, work accidents. The Arbitrator bases his finding on the more credible, reliable and persuasive opinions of Dr. Ritchie than those of Dr. Paletta.

When reviewing the records and expert testimony, Dr. Paletta agrees with the majority of Dr. Ritchie's opinions, and all of them in regard to the right knee osteoarthritis. In his August 22, 2019, office note, Dr. Paletta opined, "it appears Dr. Ritchie and I agree that any knee symptoms at this point are related to his underlying osteoarthritis." (PX 7, page 2) Dr. Paletta further states, "the need for total knee replacement would be related to the underlying degenerative osteoarthritis of the knee. Both Dr. Ritchie and I agree that this is a preexisting condition." (PX 7, page 2)

Dr. Paletta also testified that Petitioner had underlying arthritis prior to his work injuries. (PX 8, pages 7 & 26) Dr. Paletta testified that he has never diagnosed any worsening or aggravation of his underlying arthritis as a result of his work injuries. (PX 8, page 26) He testified that Petitioner had good healing of his meniscus. (PX 8, page 27) He testified that Petitioner had only lost 10% or 15% of his meniscus after his prior right knee surgery many years ago and the one he performed on February 20, 2018. (PX 8, page 9) Dr. Paletta testified that Petitioner's right knee looked good in August and December 2018, and he had good range of motion and stability. (PX 8, pages 24-25)

Dr. Ritchie testified that Petitioner's current condition in his right knee and leg was no longer related to either of his work accidents. (RX 3, page 9) He testified that Petitioner's arthritis is not related to his work injuries. (RX 3, page 9) Dr. Ritchie testified that Petitioner's current right knee and leg complaints are due to his longstanding osteoarthritis. (RX 3, page 10) He testified Petitioner has likely had arthritis for five or more years. (RX 3, page 11)

Dr. Barkmeier testified Petitioner had a deep vein blood clot in his right leg below the groin following his February 2018 right knee surgery. (RX 4, page 7-8) She testified that Petitioner's work accident and subsequent surgery caused his blood clot. (RX 4, page 8) She testified that Petitioner should use a graduated stocking support, elevate his right leg and exercise his leg muscles to improve the venous return. (RX 8, page 8) She did not have any other treatment recommendations. (RX 8, page 8) There were no contrary testimony offered by Petitioner regarding his right leg blood clots.

Based on the foregoing, as well as the credible evidence introduced at trial, and having found Dr. Ritchie's opinions to be more credible, reliable and persuasive, the Arbitrator finds that Petitioner's knee condition is at MMI. However, the Arbitrator finds the Petitioner's DVT sequelae is not at MMI and may require accommodations or treatment. The Petitioner failed to prove that his current condition of ill-being in his right knee in regard to his osteoarthritis and recommendation for an evaluation for a total knee replacement is causally related to his August 25, 2016, or June 22, 2017, work accidents.

In support of the Arbitrator's Decision relating to (J), Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Based on the parties' stipulation on the Arbitrator's Exhibit 1 and Respondent accepting liability for related medical expenses prior to July 31, 2019, the Arbitrator awards all the medical expenses in P X 16 totaling: $18,218.24 subject to the fee schedule

In support of the Arbitrator's Decision relating to (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Based on the Arbitrator's findings in regard to disputed issue (F) and having found that both Dr. Paletta and Dr. Ritchie opined that Petitioner had underlying arthritis prior to his work

injuries and did not sustain any worsening or aggravation of his underlying arthritis as a result of his work injuries, Petitioner's petition for prospective medical care for his right knee is denied. Note, the Arbitrator is not denying possible treatment for his right leg DVT sequelae.

In support of the Arbitrator's Decision relating to (L), Is Petitioner entitled to TTD, the Arbitrator finds and concludes as follows:

As of October 30, 2019, the date of Dr. Paletta's Deposition, he had the Peitioner on light duty with no squatting, no kneeling, no climbing, and lifting restrictions of 25 pounds. PX #8, pp. 20, line 19.

As of August 22, 2019 Drs. Paletta and Richie "agree that at this point the the Petitioner"s residual symptoms are due to DVT and postphebitic syndrome of his right lower extremity." PX 7, pp 1.

Dr. Barkmeier opined Petitioner was not at MMI and recommended leg elevation 3 to 4 times a day. Deposition, RX 4, pp.12 and Deposition Exh. 3 pp.1

Petitioner's restrictions were accommodated up to September 3, 2019. Arb.Trans. pp.23. On that date the Petitioner appeared for work and was sent home. The Arbitrator finds the Respondent either did not accommodate the Petitioner's restrictions or Petitioner was unable to do his job due to his DVT condition which both Drs. Paletta and Richie opined was his current residual symptom. Id.

Therefore, the Arbitrator awards Petitioner TTD from 9/4/19 through 1/24/20

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC020825
Case Name	BENNETT, LARRY v. ABF FREIGHT SYSTEMS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0401
Number of Pages of Decision	26
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Richard Salmi
Respondent Attorney	James Egan

DATE FILED: 8/9/2021

DISSENT

/s/ Kathryn Doerries, 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

LARRY BENNETT,

Petitioner,

vs. NO: 18 WC 20825

ABF FREIGHT SYSTEMS,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's finding on page 1, paragraph 1, under "Ruling on Motion" wherein the Arbitrator found that Dr. Fucetola, a neuropsychologist with a Ph.D., did not qualify as a Section 12 examiner because he was not an M.D. The Commission finds that a neuropsychologist with a Ph.D. does qualify as a Section 12 examiner.

The term "medical practitioner" is not defined in the Act. In *Texaco-Cities Serv. Pipeline Co. v. McGaw*, 182 Ill.2d 262, 270 (1998), the court commented that in construing a statute, this court strives to ascertain and give effect to the intent and meaning of the legislature, and this

effort properly begins with an examination of the statutory language. *Advincula v. United Blood Services*, 176 Ill.2d, 1, 16 (1996). Each undefined word in the statute must be ascribed its ordinary and popularly understood meaning. *Canteen Corp. v. Department of Revenue*, 123 Ill.2d 95, 105 (1986). The court should evaluate the statute as a whole and construe it, if possible, so that no term is rendered superfluous or meaningless. *Bonaquro v. County Officers Electoral Board*, 158, Ill.2d 391, 397 (1994).

The legislature did not limit Section 12 to a physician or surgeon, but specifically delineated that the exam should be by a "duly qualified medical *practitioner*". The Illinois Court of Appeals has addressed this issue in the context of whether a physical therapist would qualify as a duly qualified medical practitioner (*See W.B. Olson v. Ill. Workers' Comp. Comm'n*, 2012 IL App (1st) 113129WC ¶45). The Court held a physical therapist is not qualified under Section 12. However, Illinois Courts have not specifically weighed in on whether a PhD psychologist falls within the purview of Section 12. This case can be distinguished, however, as a physical therapist administers treatments prescribed by a physician and is also under the supervision of a physician.

Merriam Webster defines "psychologist" as a person who specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders: a specialist in psychology. It defines the word "practitioner" as 1) one who practices *especially:* one who practices a profession. Given the scope of a psychologist's practice, the Commission finds that a PhD specializing in neuropsychology is a medical practitioner as contemplated by the statute. In the instant case, Dr. Fucetola was solely responsible for conducting the psychological exam and testing and interpreting the results. The legislature could have specifically delineated in the statute that Section 12 is only applicable to medical doctors, but it did not. Clearly, the legislature limited it by designating surgeons, so the Commission finds that the intent is that medical practitioner is more broad than simply a medical doctor.

Although the Commission does find that Dr. Fucetola is a duly qualified medical practioner under Section 12 of the Act, the Commission gives his opinions no probative value for the reasons set forth in the Arbitrator's decision.

Additionally, the Commission corrects scrivener's errors in the body of the decision. On page 2 of the Arbitrator's decision, in the first sentence of the fifth full paragraph, the date should read "June 26, 2018" and not "June 25, 2018". On page 3 of the Arbitrator's decision, in the first sentence of the sixth paragraph, the date should read "September 21, 2018" instead of "September 1, 2018."

All else is affirmed and adopted

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 16, 2020 is hereby affirmed and adopted with the aforementioned modification and correction of scrivenor's error.

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 $56,248.00. 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.

August 9, 2021 /s/ *Maria E. Portela*

MEP/dmm
O: 060821
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/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

DISSENT

I disagree with the majority's award of penalties and attorney's fees under Sections 19(k), 19(l) and 16 and, therefore, dissent for the reasons stated below.

The Arbitrator awarded penalties under Section 19(l) of the Act, in the amount of $9,060.00, based upon the 4 days of TTD that were not paid for the period of July 9, 2018, through July 12, 2018 (and arguably one other day the Arbitrator found was unpaid, but not identified, lost time). The Arbitrator calculated Section 19(l) penalties by multiplying $30.00 per day for 302 days that the TTD was unpaid after the Petitioner's attorney made a demand for the four identified days, July 9, 10, 11 and 12, 2018. The Arbitrator also awarded $7,077.44 in penalties under Section 19(k) of the Act, penalties that represented 50% of the total unpaid temporary total disability (TTD) benefits including the four days previously identified, the unidentified day, and the period commencing October 6, 2019 through the hearing date on February 27, 2020. The Arbitrator calculated the Section 19(k) penalties by calculating the total TTD awarded and subtracting the amount of TTD Respondent had paid, finding that Respondent owed penalties on the entire amount of unpaid TTD and dismissing Respondent's defenses to be "unreasonable and vexatious." The Arbitrator also awarded attorney's fees, pursuant to Section 16, in the amount of $1,415.49, an

amount representing 20% of the Section 19(k) penalties awarded to Petitioner. Based on the evidence presented, I would find the awarded penalties and attorney's fees under Sections 19(k), 19(l) and 16 are not warranted for the reasons set forth below.

The pertinent sections of the Illinois Workers' Compensation Act ("Act") state as follows:

Penalties under Section 19(l)

> If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l).*

Penalties under Section 19(k)

> In case 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)* (2013).

Attorneys' Fees under 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 underpayment 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 insurance carrier. *820 ILCS 305/16 (2013).*

Analysis

Section 19(l) Penalties

"Penalties under section 19(l) are in the nature of a late fee" and are "mandatory '[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show adequate justification for the delay.'" *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 Il App (3d) 100807WC, ¶ 20, 959 N.E.2d 772, 355 Ill. Dec. 358 (quoting *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552, 234 Ill. Dec. 205 (1998)). "The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness." *Id.* When benefits are withheld for 14 days or more, a rebuttable presumption of unreasonable delay exists. 820 ILCS 305/19(l) (West 2012). "The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 20, 959 N.E.2d at 777-78.

Although Respondent did not pay TTD for four days, July 9, 2018, through July 12, 2018, Respondent had good and just cause for not commencing Petitioner's TTD benefits. Petitioner was released to light duty work on June 26, 2018, through Barnescare. Petitioner testified he returned to light duty work. (T.18-19) Petitioner testified that Respondent accommodated and provided light duty. (T. p. 18)

However, thereafter, Petitioner went to his chiropractor for treatment on July 2, 2018. Petitioner had been seeing this chiropractor for 18 years; thus, Petitioner had a long-term relationship with him. The chiropractor, Zimmer, took him off work providing a work status/disability note for July 2, 2018 through July 13, 2018. Respondent relied upon the light duty release issued by Barnescare West Port, yet, Respondent was assessed $9,060.00 in penalties for those 4 days of unpaid TTD benefits, more than three times the amount of disputed TTD. The Respondent's reliance upon the Barnescare release was good and just cause for refusal to pay TTD when, it appears that Petitioner, rather than working light duty, sought out his chiropractor, with whom he had an 18-year-relationship, who then provided an opinion that he should remain off work. At his follow-up visit at Barnescare on July 3, 2018, Petitioner advised, and for some reason misrepresented, that he had no treatment, test or therapy since his last visit and was working light-duty when he had obviously seen his chiropractor the day before. His restrictions were continued by Barnescare.

Petitioner returned to his chiropractor's office on July 6, and July 9, 2018. Again, the disputed TTD period was July 9, 2018, through July 12, 2018. Thus, it appears that Petitioner was working on July 3, 2018, as reported to Barnescare, and continued to work through July 8, 2018,

despite his chiropractor's off work note. However, as of July 9, 2018, Petitioner took off work with no explanation at the arbitration hearing as to the reason he could work light duty for some of the days but not others. Petitioner did not testify to any worsening of his condition at that time. He returned to the chiropractor on July 13, 2018, and was then referred for an orthopedic evaluation.

Petitioner chose Dr. Solman an orthopedic surgeon. Dr. Solman's initial consult note on July 18, 2018, documents that the Petitioner had been seeing his chiropractor since 2000, a period of 18 years, and documents his twenty year history of back pain and right shoulder surgery 4-5 years prior. (PX8) Petitioner reported no problems in his right shoulder after the surgery, however, that history that Petitioner gave Dr. Solmon regarding any subsequent problems in his right shoulder is only as good as Petitioner's credibility, which, unlike the majority, I find unreliable. Although Petitioner told Dr. Solman he had no problems with his shoulder after his prior surgery, on June 26, 2018, one day after the accident, Barnescare documented Petitioner reported a "prior history of right shoulder strain ***a year ago***, as well as bone spur removal in the past." (emphasis added)

On July 18, 2018, at his first consult, Dr. Solman opined that Petitioner could work light-duty. Dr. Solman made the following statement regarding Petitioner's work status: "could be working limited duties with clerical duties only with the right arm. I would also have him avoid any repetitive motions with the right arm more than 15 times per hour and no overhead lifting above shoulder level. He will probably remain off of work now however, ***because there is no light duty available for him***." (emphasis added) Thus, Petitioner's light-duty capability was verified by Dr. Solman. However, the work status note provided by Dr. Solmon instead read, "recommend he remain off work until he follows up after MRI." This work status note was inconsistent with Dr. Solman's opinion that Petitioner could work, but clearly and unequivocally, Dr. Solman provided an off work note based on the Petitioner's advice that there was no light duty available for him.

The Respondent had good and just cause to withhold TTD for four days under this set of facts. Two medical providers including an orthopedic surgeon agreed Petitioner could work light duty, however, a chiropractor with whom he had an 18 year relationship, provided Petitioner an off-work slip. The majority's decision to penalize the Respondent under this set of facts is just the type of draconian and dangerous precedent that will ultimately drive businesses out of the State of Illinois and result in a loss of those jobs in the State. In the end, this kind of precedent results in detrimental consequences for all workers in Illinois.

Section 19(k) Penalties and Attorneys' Fees under Section 16

The *McMahan Court* held:

> An award of penalties and attorney fees pursuant to §19(k) and §16 are "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other

> than legitimate motives." *McMahan v. Industrial Comm'n*, 289 Ill. App. 3d 1090, 1093, 683 N.E.2d 460, 463, 225 Ill. Dec. 292 (1997), *aff'd*, 183 Ill. 2d 499, 702 N.E.2d 545, 234 Ill. Dec. 205 (1998). The standard for awarding penalties and attorney fees under §19(k) and 16 of the Act is higher than the standard for awarding penalties under §19(l) because §19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552, 234 Ill. Dec. 205 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, §19(k) penalties and §16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553.

The Arbitrator found Respondent's refusal to pay Petitioner weekly compensation benefits after October 5, 2019, to be unreasonable and vexatious. (AD, p. 9) The majority, by affirming the Arbitrator, concluded that "the only medical opinion Respondent has to base a termination of TTD benefits is that of Dr. Crane and it is limited to Petitioner's neck/cervical spine condition. However, as noted herein, Petitioner had a number of other conditions, which, in and of themselves, would prevent Petitioner from returning to work. Petitioner was just seen by Dr. Davidson, an optometrist selected by Respondent, just two days prior to trial and she has continued to impose restrictions which prohibit Petitioner from returning to work as a commercial truck driver." (AD, p. 9)

My first issue with the majority's conclusion is that Respondent's conduct was not done in "bad faith" or "improper purpose" or due to an "unreasonable delay" in light of the multiple findings that Petitioner had reached maximum medical improvement (MMI) before his benefits were terminated. In fact, this finding ignores the fact that Respondent relied not only on the chiropractor, Dr. Zimmer's opinion that Petitioner was at MMI for his neck/cervical spine on December 26, 2018, but also, as noted, on Dr. Crane's opinion that Petitioner was at MMI on May 5, 2019. Dr. Crane credibly opined that he did not appreciate any critical stenosis, as described by Dr. Raskas on either the CT myelogram or the MRI scan. Furthermore, he did not appreciate any evidence for significant myelopathy of the upper or lower extremities. He felt that Petitioner had neck pain and non-work-related bilateral carpal tunnel syndrome. He opined that Petitioner was at MMI and could return to work without restrictions. Finally, Dr. Crane noted, "[t]he functional capacity evaluation performed at Athletico, is reviewed, demonstrates that he gave a full and consistent effort meeting all of his job demands." (RX1, DepX2)

Respondent also reasonably relied upon Dr. Fucetola's report, written after the October 1, 2019 Section 12 evaluation, notwithstanding the fact that the majority gives Dr. Fucetola's report no probative value. I agree with the majority that Dr. Fucetola, a neuropsychologist who treats either injury to, or disease of, the brain that may be more neurologic in nature or psychiatric in

nature is a medical practitioner as contemplated by the Illinois legislature when drafting Section 12 of the Act.

My second issue with the majority 's opinion, however, is that Dr. Fucetola's report was given no probative value. The *Frye* standard does not require that the psychologist's test questions and the results be published, but instead requires that the method that was the basis for the expert's opinion is accepted by the expert's peers in the scientific community. This was explained by the Fourth District Appellate Court in deciding whether a pulmonologist could rely on two journal articles as the basis for his expert opinion:

> The purpose of the *Frye* test is to exclude new or novel scientific evidence that undeservedly creates 'a perception of certainty when the basis for the evidence or opinions is actually invalid.'" *Detention of New*, 2014 IL 116306, ¶ 26, 21 N.E.3d 406 (citations omitted). We review *de novo* whether a methodology or principle is generally accepted in the relevant scientific community. *Detention of New*, 2014 IL 116306, ¶ 26, 21 N.E.3d 406.
>
> [*P34] In determining whether an expert's opinion is admissible under *Frye*, our focus is on whether the underlying method used to generate the expert's opinion is one that is reasonably relied upon by the experts in the field. *Donaldson*, 199 Ill. 2d at 79, 767 N.E.2d at 325. "If the underlying method used to generate an expert's opinion is reasonably relied upon by the experts in the field, the fact finder may consider the opinion—despite the novelty of the conclusion rendered by the expert." *Id.* at 77, 767 N.E.2d at 324.
>
> [*P35] We note the arbitrator here did not conduct a separate *Frye* hearing. However, that does not impair our review. We noted the existence of similar circumstances in *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 594, 840 N.E.2d 300, 310, 298 Ill. Dec. 530 (2005):
>
> *HN5* "During a worker[s'] compensation arbitration hearing, most expert testimony [***19] is received via evidence depositions. In most cases, it would be impractical and inconsistent with the general nature of worker[s'] compensation proceedings to require a separate *Frye* hearing with live witnesses. Here, the arbitrator and the Commission considered all of the expert deposition testimony and the *Frye* standard and then ruled on the admissibility of claimant's proposed expert testimony. *** The arbitrator and the Commission considered all of the evidence relevant to the *Frye* issue before ruling on the admissibility of [the expert's] testimony and dealt with the issues they would have addressed had a separate *Frye* hearing been held. Therefore, we believe that the procedure employed here was appropriate."

Durbin v. Ill. Workers' Comp. Comm'n, 2016 IL App (4th) 150088WC, P33-P35, 56 N.E.3d 605, 613, 2016 Ill. App. LEXIS 478, *18-19, 404 Ill. Dec. 621, 629.

In the subject case the basis for Dr. Fucetola's opinion was, in fact, tests that his scientific community relies upon to diagnose patients and for which he was ethically bound not to disclose. Dr. Fucetola explained as follows:

> First, I am bound by the Ethical Standards of American Psychological Association which precludes psychologists from releasing test questions, raw data into the public domain because, of course, any standardized test that's released into the public immediately becomes ineffective. In other word, if the test questions are available to anyone, they are no good anymore. (RX2 p. 15)

This is the antithesis of the *Frye* standard. By disclosing the tests, they would no longer be valid. Dr. Fucetola testified that the reason he could not release these reports was based in part upon section 9.04 of the Ethical Principals of Psychologist and Code of Conduct. They are also "based on position papers that have been put out by the major professional organizations and scientific organizations in my field which make it clear we are prohibited from releasing this information into the public. I would like to just testify again I was not taken up on the offer but I offered to provide the numerical data in table form and no one took me up on it." (RX2, p. 25)

However, his opinion was based upon the methodology relied upon by his peers and therefore, I would afford his opinion significant weight. As Dr. Fucetola explained:

> Under the test results, these are objective findings based upon the various tests that Petitioner took. I can summarize the test results and my conclusions. Let's just preface what I'm going to say by just saying that all of these tests that Petitioner took yield or produce quantitative or numerical scores that tell us where his performance stands relative to a man who is 54 years old who has a 10th grade education essentially. There are data on all these tests that tell us what's normal or expected given a person's age and education and so forth. (RX2, p. 17)

Moreover, for the purpose of determining Petitioner's concussion condition, the Respondent was, in fact, reasonably relying upon Dr. Fucetola's expert opinion to terminate Petitioner's TTD benefits and therefore, the majority should not impose penalties, nor should the Respondent be burdened with penalties, for defending their case with tools provided in the Act, specifically a Section 12 opinion. The fact that Respondent relied upon Dr. Fucetola's report was in and of itself done in good faith awaiting the Arbitration rulings on the admissibility of the report. Further, the report itself casts considerable doubt upon Petitioner's credibility, akin to an invalid FCE, but due to neuropsychological testing of the brain. Dr. Fucetola explained,

> In my conclusions I indicate that the current neuropsychological evaluation results are not believed to represent a true picture of Petitioner's capabilities. He earned extremely low scores on some tests; but he failed multiple performance validity tests suggesting that he did poorly but wasn't trying his best. He showed something that's very atypical which is that he hit his head in this according to what he told

> me and the records, and so I thought that it was possible he had a mild concussion as part of the fall that day, and yet his performance on those tests was grossly out of proportion to that which you could see in someone who had a mild concussion. He also performed normally on some of the tests in my battery that are considered most sensitive to concussion in general. In other words, he did okay on the tests that should have been affected if there was a concussion and earned extremely low scores on tests where there shouldn't have been very low scores. And I found that perplexing, but the performance validity testing would suggest that for whatever reason Petitioner was not putting forth full effort. (RX2, pp. 19-20)

On June 11, 2019, Dr. Wolf's opinion regarding the Petitioner's concussive symptoms was that if, after neuropsychological testing results the Petitioner did not need additional treatment, then Petitioner would be at MMI. Since Dr. Fucetola opined that Petitioner was at MMI, then Dr. Wolf would also be of the opinion that he was at MMI for his concussive symptoms. Dr. Yazdi found Petitioner to be at MMI on March 20, 2019 for his right shoulder. On June 14, 2019, Dr. Solman opined Petitioner was at MMI for his right shoulder. Thus, although the majority found that Petitioner was still seeing Dr. Davidson, Petitioner testified that his basic vision is fine. (T. p. 36) Petitioner continued to see Dr. Davidson because he was allegedly having problems with 3D vision. Clearly from the March 16, 2019, surveillance showing Petitioner driving approximately one hour on the highway to Desoto, MO, the Respondent had a reasonable defense to his claim that he cannot drive. The April video surveillance showed Petitioner driving locally. Respondent obviously could not reconcile the fact that Petitioner was driving on the highway with Petitioner's allegation he could not drive a commercial vehicle. Several weeks after terminating TTD, the Respondent obtained surveillance of Petitioner attaching an ATV to his pickup truck, then driving, and speeding, on the highway, again to Desoto, MO which only would serve to bolster the dichotomy between the restriction and Petitioner's capability. The surveillance alone is a good faith defense.

In addition, Petitioner failed his Department of Transportation (DOT) return to work test on September 16, 2019, based on claims of vertigo, noted balance issues and depth perception. (PX14)

While Petitioner reported tinnitus, he reported that he heard the whisper test and this report of tinnitus is not credible given that Dr. Yazdi's office note on August 20, 2018, one year before the DOT test, documented that Petitioner had reported that the ringing in his ear was almost resolved and his hearing was back to baseline. (PX5) However, Petitioner testified that he has ringing in his ear all the time. (T. p. 20) Based upon Dr. Yazdi's note, I find Petitioner is not credible in this regard.

Petitioner failed the "finger to nose" depth perception test although previously, and after the work accident, a "finger to nose" test was normal, both on July 3, 2018, and again on August 20, 2018. (PX2) On July 3, 2018, Barnescare noted that a Romberg test was negative and his tandem gait was normal. (PX2) On March 20, 2019, Dr. Yazdi noted that Petitioner had no drift

on exam and that his gait was intact, yet the Petitioner failed the DOT test based, in part, on a "pronator drift" and lack of ability to ambulate on his heels and toes. The treating records belie these findings further justifying Respondent's good faith defense.

While I will agree that TTD should be awarded, there is no evidence that the termination of Petitioner's benefits on October 5, 2019, was done deliberately, in bad faith or for an improper purpose but instead on good faith defenses and based on all the afore-referenced reasons, do not merit the imposition of penalties under Section 19(k) or the award of attorney's fees under Section 16.

Therefore, I dissent from the majority opinion and would reverse the Arbitrator's decision awarding penalties under Section 19(k), 19(l) and attorney's fees under Section 16.

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

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

21IWCC0401

BENNETT, LARRY
Employee/Petitioner

Case# **18WC020825**

ABF FREIGHT SYSTEMS
Employer/Respondent

On 4/16/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6296 JSK LAW OFFICES
RICHARD E SALMI
331 SALEM PL SUITE 260
FAIRVIEW HTS, IL 62208

2965 KEEFE CAMPBELL BIERY & ASSOC
JAMES EGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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)

Larry Bennett
Employee/Petitioner

v.

ABF Freight Systems
Employer/Respondent

Case # 18 WC 20825

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on February 27, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, June 25, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $35,592.59; the average weekly wage was $988.68.

On the date of accident, Petitioner was 52 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $42,905.80 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $42,905.80.

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner as identified in Petitioner's Exhibit 16, 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 C5-C6 and C6-C7 fusion surgery as recommended by Dr. David Raskas.

Respondent shall pay Petitioner temporary total disability benefits of $659.12 per week for 86 4/7 weeks, commencing July 2, 2018, through February 27, 2020, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner Section 19(k) penalties of $7,077.44, Section 19(l) penalties of $9,060.00 and Section 16 Attorneys' Fees of $1,415.49.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 11, 2020
Date

APR 16 2020

Ruling on Motion

Respondent had Petitioner evaluated by Robert Fucetola, Ph.D., a neuropsychologist, on October 1, 2019. This was not a Section 12 examination of Petitioner because Section 12 pertains to an employer obtaining a "Medical Examination" by a "duly qualified medical practitioner or surgeon." A neuropsychologist with a Ph.D., and not an M.D., is not so qualified.

Fucetola was deposed on February 5, 2020. At that time, Petitioner's counsel made a motion to strike Fucetola's testimony in its entirety. Petitioner's counsel noted that Fucetola refused to provide information regarding various tests he had administered to Petitioner and that Fucetola only disclosed his opinions and not the test forms, the questions contained therein or Petitioner's responses.

Petitioner's counsel argued that Petitioner was prejudiced from determining the basis of Fucetola's opinions, lack of foundation, unfair surprise, hearsay, a *Ghere* violation and the fact Fucetola declined to produce the test data created a negative inference regarding its outcome (Respondent's Exhibit 2; pp 4-5).

When he was deposed, Fucetola explained the basis for his refusal to disclose the test information. He testified ethical standards prohibited him from releasing the questions because, if he did so, they would be in the public domain and ineffective. He also stated the producers of the tests consider them to be trade secrets and psychologists who use them could only disclose them to another psychologist or qualified expert. Fucetola also prepared and signed an affidavit on December 10, 2019, which contained the preceding information (Respondent's Exhibit 2; pp 15-16; Deposition Exhibit 1).

The Arbitrator has considered the arguments made by Petitioner's counsel and Fucetola's basis for declining to release the test data. Based upon Fucetola's testimony, he was bound both by ethical concerns and the fact that the producers of the tests consider them to be trade secrets and not to be disclosed.

Accordingly, the Arbitrator denies the motion to strike Fucetola's testimony. However, the points made by Petitioner's counsel in his argument in support of his motion to strike Fucetola's testimony significantly impact the probative value of Fucetola's testimony/opinions. While the Arbitrator has denied Petitioner's motion to strike Fucetola's testimony, he finds Fucetola's testimony/opinions to have no probative value and gives no weight to same.

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 25, 2018. According to the Application, Petitioner sustained an accident when a "Kingpin suddenly came free and Petitioner fell backward" which caused Petitioner to sustained an injury to his "Head, neck, right shoulder and BAW" (Arbitrator's Exhibit 2). Petitioner claimed he was entitled to temporary total disability benefits of 86 4/7 weeks, commencing July 2, 2018, through February 27, 2020 (date of trial). Respondent claimed Petitioner was not entitled to temporary total

disability benefits after October 5, 2019. However, Respondent paid Petitioner temporary total disability benefits of $42,905.80, which at the rate of $659.12 per week computes to approximately 65 1/7 weeks (Petitioner's Exhibit 1).

July 2, 2018, through October 5, 2019, 65 6/7 weeks, is a difference of five days. On May 2, 2019, counsel for Petitioner sent an e-mail to counsel for Respondent demanding payment of temporary total disability benefits for four days (July 9, to July 12, 2018). Respondent's counsel sent Petitioner's counsel an e-mail which indicated Respondent had light duty available for Petitioner during the aforestated period of time, but Petitioner did not show (Petitioner's Exhibit 15).

Respondent refused to pay Petitioner temporary total disability benefits for the four days demanded by Petitioner's counsel (the period of time was computed by the Arbitrator to be five days – 65 6/7 weeks - 65 1/7 weeks = 5/7 weeks or five days). On January 24, 2020, Petitioner's counsel filed a Petition for Sections 19(k) and 19(l) penalties and Section 16 Attorneys' Fees regarding Respondent's refusal to pay aforementioned four (five) days of temporary total disability benefits and its termination of temporary total disability benefits on October 5, 2019 (Petitioner's Exhibit 18).

Petitioner worked for Respondent as a truck driver. Petitioner's job duties also included loading/unloading freight. Prior to the accident of June 25, 2018, Petitioner was working full duty and he denied any prior neck or post-concussion symptoms.

On June 25, 2018, Petitioner was in the process of unhooking a fifth wheel. The kingpin was stuck and Petitioner had to pull with a significant amount of force. When he did so, the wheel suddenly released which caused Petitioner to fall backward. This caused Petitioner to hit a trailer that was behind him and he struck his head.

Petitioner initially sought medical treatment at BarnesCare on June 25, 2018. At that time, Petitioner was evaluated by Molly Haynes, a Nurse Practitioner. Petitioner complained of right shoulder and head pain. An x-ray of the right shoulder was obtained which revealed degenerative changes, but no fracture. A CT scan of the head was obtained which revealed no acute abnormality. NP Haynes restricted Petitioner from driving and ordered physical therapy (Petitioner's Exhibits 2 and 3).

At trial, Petitioner testified Respondent initially provided him with light duty work. However, on July 2, 2018, Petitioner was evaluated by Dr. Michael Zimmer, a chiropractor. At that time, Petitioner complained of right shoulder pain, bilateral neck pain, right knee pain and ringing in his ears. Dr. Zimmer authorized Petitioner to be completely off work (Petitioner's Exhibit 4).

Dr. Zimmer referred Petitioner to Dr. Corey Solman, an orthopedic surgeon, who evaluated Petitioner on July 18, 2018. Dr. Solman diagnosed Petitioner with a right rotator cuff strain and ordered an MRI scan (Petitioner's Exhibit 8). The MRI was performed on July 25, 2018. According to the radiologist, the MRI revealed a partial thickness tear at the junction of the supraspinatus and infraspinatus tendons, mild subacromial subdeltoid bursitis and marked acromioclavicular joint osteoarthrosis (Petitioner's Exhibit 7).

When Dr. Solman saw Petitioner on August 3, 2018, he reviewed the MRI scan and recommended Petitioner undergo arthroscopic surgery. On November 15, 2018, Dr. Solman performed arthroscopic surgery on Petitioner's right shoulder. The procedure consisted of debridement of the labrum, subacromial decompression, distal clavicle resection and supraspinatus repair (Petitioner's Exhibits 8 and 9).

Following surgery, Dr. Solman continued to treat Petitioner and ordered physical therapy. Petitioner received physical therapy from December 4, 2018, through April 10, 2019. At that time, the therapist opined Petitioner had no significant right shoulder symptoms and could perform all of his job functions; however, it was noted Petitioner was still limited by dizziness and a lack of ability to climb (Petitioner's Exhibit 10). Dr. Solman subsequently released Petitioner to return to work without restrictions in regard to his right shoulder on June 14, 2019 (Petitioner's Exhibit 8).

Because of his neck and head symptoms, Petitioner sought treatment from Dr. Joseph Yazdi, a neurosurgeon. Dr. Yazdi initially examined Petitioner on July 23, 2018. Dr. Yazdi diagnosed Petitioner with a brain concussion, post-concussion syndrome, cervical strain and headache. Dr. Yazdi ordered cognitive and compensatory training (Petitioner's Exhibit 5).

Dr. Yazdi saw Petitioner on August 20, 2018, and noted approval had not been given for the cognitive and compensatory training that he had ordered. Petitioner complained of being forgetful, having difficulties concentrating, being unable to multitask and losing his balance. Dr. Yazdi renewed his recommendation for Petitioner to have cognitive therapy (Petitioner's Exhibit 5).

When Dr. Yazdi saw Petitioner on September 20, 2018, Petitioner continued to complain of memory issues as well as significant neck pain which extended into the shoulder blades. Dr. Yazdi opined Petitioner had cervical facet syndrome which was caused by the accident. He administered facet injections at C5-C6, C6-C7 and C7-T1, which caused a reduction in Petitioner's symptoms. Dr. Yazdi also ordered an MRI scans of Petitioner's cervical spine (Petitioner's Exhibit 5).

The MRI was performed on September 1, 2018. According to the radiologist, the MRI revealed degenerative disc/joint disease and disc osteophyte complexes at C5-C6 and C6-C7 (Petitioner's Exhibit 7).

Dr. Yazdi saw Petitioner on October 4, 2018, and reviewed the MRI scan. He opined it revealed a central/broad disc herniation with osteophytes at C5-C6. He continued to treat Petitioner for his cognitive problems (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Benjamin Crane, an orthopedic surgeon, on December 28, 2018. In connection with his examination of Petitioner, Dr. Crane reviewed medical records and diagnostic tests provided to him by Respondent. At that time, Petitioner was recovering from the right shoulder surgery. Dr. Crane's examination was primarily in regard to Petitioner's neck symptoms. He reviewed the MRI of September 21, 2018, and

opined it revealed disc height loss at C5-C6 and C6-C7, but no significant disc bulging. Dr. Crane diagnosed Petitioner with neck pain and recommended physical therapy. He imposed light duty work restrictions of no bending, pulling, pushing, stooping, no lifting in excess of 10 pounds and no overhead lifting (Respondent's Exhibit 1; Deposition Exhibit 2).

Because of Petitioner's neck symptoms, Dr. Solman referred Petitioner to Dr. David Raskas, an orthopedic surgeon. Dr. Raskas initially evaluated Petitioner on March 12, 2019. Dr. Raskas reviewed medical records for treatment received in regard to Petitioner's neck condition. He noted Dr. Yazdi had performed facet blocks at C5-C6 and C6-C7 in September, 2018. Petitioner complained of neck pain as well as the cognitive problems he had experienced since the accident. Dr. Raskas reviewed the MRI and noted there was a posterior osteophyte complex at C5-C6 and C6-C7, as well as severe right foraminal stenosis at C5-C6. He ordered a CT myelogram (Petitioner's Exhibit 5).

On March 20, 2019, Petitioner was again seen by Dr. Yazdi. Petitioner continued to complain of headaches, vertigo, tinnitus, blurry vision and significant memory loss. Dr. Yazdi opined Petitioner had a concussion injury of the cerebrum and post-concussion syndrome. He opined Petitioner was at MMI; however, he also opined Petitioner had permanent deficits as a result of the head injury. Dr. Yazdi noted Petitioner needed to avoid heavy lifting, walk only on flat surfaces and have accommodations when having to climb or descend (Petitioner's Exhibit 5).

The myelogram and CT scan were performed on March 28, 2019. According the radiologist, the myelogram revealed stenosis at C5-C6 and C6-C7 and the CT scan revealed a right paracentral protrusion at C5-C6 and a central protrusion at C6-C7 (Petitioner's Exhibit 12).

Dr. Raskas saw Petitioner on April 12, 2019, and reviewed the diagnostic studies. He recommended Petitioner undergo an anterior discectomy and fusion with plating at C5-C6 and C6-C7. He opined the work injury caused the disc pathology and cervical radiculopathy and that Petitioner was authorized to be off work (Petitioner's Exhibit 11).

At the direction of Respondent, Petitioner was again examined by Dr. Crane on May 6, 2019. In connection with his examination of Petitioner, Dr. Crane reviewed up-to-date medical records as well as the myelogram and CT scan performed on March 28, 2019. He opined the diagnostic studies did not reveal any significant abnormalities, including the stenosis noted by Dr. Raskas. Dr. Crane opined Petitioner had neck pain, was at MMI and could return to work without restrictions (Petitioner's Exhibit 1; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Christopher Wolf, an osteopathic physician, on June 11, 2019. He evaluated Petitioner for complaints related to his head injury. In regard to Petitioner's memory/concentration issues, he expressed doubts that they could be continuing so long after the injury, but recommended a neuropsychological test. However, he opined Petitioner's complaints in regard to vision, dizziness and headaches were related to the accident. In regard to the concussion, he opined Petitioner was not at MMI (Respondent's Exhibit 3).

Dr. Raskas was deposed on August 28, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Raskas' testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, Dr. Raskas testified Petitioner had a cervical herniated disc with cervical myelopathy and cervical spondylosis. In regard to causality, Dr. Raskas testified the accident caused the herniated disc and myelopathy and aggravated the spondylosis. He recommended Petitioner undergo an anterior discectomy and fusion at C5-C6 and C6-C7 (Petitioner's Exhibit 1; pp 22-24).

At the direction of Respondent, Petitioner was evaluated by Dr. Cheryl Davidson, an optometrist, associated with the Center for Vision & Learning, on August 30, 2019. At that time, Petitioner complained of blurred vision, light sensitivity and headaches. Dr. Davidson opined Petitioner had sustained a concussion and convergence insufficiency. She instituted a vision therapy course of treatment and restricted Petitioner to driving only in residential areas, no commercial driving and limited Petitioner to 30 minutes of visual activities of reading and using a computer. Dr. Davidson has continued to treat Petitioner and last saw him on February 25, 2020. The restrictions on Petitioner's activities she previously imposed remained in place at that time (Petitioner's Exhibit 13).

Dr. Crane was deposed on September 11, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Crane's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Crane testified Petitioner had a loss of disc height at C5-C6 and C6-C7 which was present prior to the accident, had neck pain, was at MMI and could return to work without restrictions (Respondent's Exhibit 1; pp 9-15).

At the direction of Respondent, Petitioner was evaluated by Robert Fucetola, a neuropsychologist, on October 1, 2019. As noted herein, Fucetola had several tests administered to Petitioner to determine if Petitioner was at MMI from a neuropsychological point of view. Based on his evaluation and review of the tests, he opined there was no evidence of a residual cognitive/intellectual or emotional/psychological disability as a result of the accident (Respondent's Exhibit 2; Deposition Exhibit 3).

Dr. Raskas again saw Petitioner on December 31, 2019. Petitioner advised his neck symptoms had worsened. He informed Dr. Raskas he attempted to go deer hunting, but was only able to sit up in a deer stand for about 30 minutes. Petitioner also advised he attempted to hook up a trailer, but after he did so, he had to sit down and rest for about 30 minutes. Dr. Raskas renewed his recommendation Petitioner undergo fusion surgery at C5-C6 and C6-C7. He also ordered a new MRI scan (Petitioner's Exhibit 11).

The MRI was performed on January 6, 2020. According to the radiologist, it revealed a disc bulge at C5-C6 and a disc protrusion at C6-C7 (Petitioner's Exhibit 11).

Fucetola was deposed on February 5, 2020. As previously noted herein, Petitioner's counsel objected to his testimony made a motion that it be stricken in its entirety. While the Arbitrator denied the motion, he found that Fucetola's refusal to provide information regarding the test significantly impacted the probative value of his testimony/opinions and the Arbitrator ruled that

his testimony/opinions had no probative value. In any event, Fucetola's testimony was consistent with the opinions he expressed in his report.

Dr. Raskas saw Petitioner on February 7, 2020, and reviewed the MRI that had just been performed. He renewed his recommendation Petitioner undergo fusion surgery at C5-C6 and C6-C7 and expressed concern that the unnecessary delay in Petitioner's treatment could cause him permanent injury (Petitioner's Exhibit 11).

Respondent tendered into evidence surveillance video and reports concerning surveillance of Petitioner which was conducted in February, March, April, October and November, 2019. Roy Helnich, the individual who conducted the surveillance testified on behalf of Respondent at trial (Respondent's Exhibit 4).

On direct examination, Helnich testified that Petitioner was not observed doing anything out of the ordinary or inconsistent with his claim that he was disabled. The only exception to this was approximately five minutes of video obtained of Petitioner on November 22, 2019, when he attempted to attach a truck to a hitch. Petitioner had considerable difficulty performing this task and got on top of the rod and jumped on it to attach it to the hitch (Respondent's Exhibit 4).

On cross-examination, Helnich agreed he conducted 17 days of surveillance for a total of approximately 132 hours with one hour of video. Out of this entire time, he only observed Petitioner for about five minutes attempting to hook up a trailer which was arguably the only time Petitioner was observed doing anything that may be inconsistent with his claim that he was disabled.

At trial, Petitioner testified he continues to have neck pain for which he takes hydrocodone. He has continued to be treated by Dr. Davidson and the restrictions she imposed are still in place. In regard to his attaching a truck to a hitch on November 22, 2019, he testified it was very painful for him to perform this task.

Conclusions of Law

In regard to disputed issue (F) Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of June 25, 2018.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained an injury to his right shoulder which required arthroscopic surgery.

As a result of the accident, Petitioner sustained a brain concussion and post-concussion syndrome. Petitioner has experienced various cognitive issues including memory loss, difficulty concentrating, inability to multitask, headaches, vertigo, dizziness, tinnitus and blurred vision. Dr. Yazdi, a neurosurgeon, opined Petitioner had permanent deficits as a result of the accident.

Respondent's Section 12 examiner, Dr. Wolf, an osteopathic physician, opined Petitioner's memory/concentration issues were not related to the accident, but that Petitioner's headaches, dizziness and vision problems were related to the accident. Respondent's examining neuropsychologist, Robert Fucetola, opined there was no evidence of a residual cognitive disability. However, as noted herein, the Arbitrator has found Fucetola's testimony/opinions to have no probative value.

In regard to Petitioner's vision problems, Respondent had Petitioner examined by Dr. Cheryl Davidson, an optometrist, who subsequently treated Petitioner. She opined Petitioner sustained a concussion and convergence insufficiency. She last saw Petitioner on February 25, 2020, just two days prior to trial.

The Arbitrator finds the opinion of Dr. Yazdi to be more persuasive than that of Dr. Wolf. As aforestated, the Arbitrator determined Fucetola's testimony/opinions to have no probative value. Further, Dr. Davidson's opinion was unrebutted.

Dr. Raskas, Petitioner's primary treating physician for his neck/cervical spine, opined that Petitioner has disc pathology at C5-C6 and C6-C7 and that Petitioner should undergo fusion surgery at those levels.

Respondent's Section 12 examiner, Dr. Crane, opined Petitioner had neck pain, but there were no significant abnormalities in the cervical spine and Petitioner was at MMI.

In regard to Petitioner's neck/cervical spine condition, the Arbitrator finds the opinion of Dr. Raskas to be more persuasive than that of Dr. Crane in regard to causality.

In regard to disputed issue (J) 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 Exhibit 16, 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 fusion surgery at C5-C6 and C6-C7 as recommended by Dr. Raskas.

In support of this conclusion the Arbitrator notes following:

As aforestated, the Arbitrator found the opinion of Dr. Raskas to be more persuasive than that of Dr. Crane in regard to causality.

Petitioner continues to have neck/cervical spine symptoms and Dr. Raskas has recommended Petitioner undergo fusion surgery at C5-C6 and C6-C7.

In regard to disputed issue (L) Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 86 4/7 weeks, commencing July 2, 2018, through February 27, 2020.

In support of this conclusion the Arbitrator notes the following:

Petitioner continues to experience various cognitive issues which Dr. Yazdi has opined are permanent deficits.

Dr. Davidson, an optometrist who initially examined Petitioner had the request of Respondent, but subsequently began treating Petitioner, has opined Petitioner is limited to driving in residential areas and is not to do any commercial driving.

Dr. Raskas has treated Petitioner for his neck/cervical spine condition, has recommended Petitioner undergo fusion surgery at C5-C6 and C6-C7 and has authorized him to be off work.

In regard to disputed issue (M) Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to Section 19(k) penalties of $7,077.44, Section 19 (l) penalties of $9,060 and Section 16 Attorneys' Fees of $1,415.49.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner was temporarily totally disabled from the time Dr. Zimmer authorized Petitioner to be off work effective July 2, 2018, through October 5, 2019 (when Respondent terminated temporary total disability benefits) a period of 65 6/7 weeks. Respondent paid Petitioner temporary total disability benefits for 65 1/7 weeks, a difference of five days.

On May 2, 2019, Petitioner's counsel send an e-mail to Respondent's counsel demanding payment of four days (computed by the Arbitrator to be five days), but Respondent refused to make payment of same.

The Arbitrator finds there was no basis for Respondent's refusal to pay Petitioner the five days of temporary total disability benefits owed to him. Accordingly, Section 19(l) penalties are mandated. Petitioner's counsel tendered his demand on May 2, 2019, and the case was tried on February 27, 2020, 302 days later. 302 days at $30.00 per day equals $9,060.00.

Respondent's decision to terminate Petitioner's temporary total disability benefits effective October 5, 2019, was presumably based on the opinion of Fucetola, the video surveillance and the opinion of Dr. Crane regarding Petitioner's neck cervical condition. None of the preceding provided a basis for termination of temporary total disability benefits in this case. Further, as was noted herein, the Arbitrator determined the testimony of Fucetola to have no probative value.

Respondent had Petitioner under surveillance on various dates in February, March, April, October and November, 2019, a period of 17 days. The individual who conducted the surveillance testified that over the course of 132 hours which he observed Petitioner, he found nothing inconsistent with Petitioner's claim that he was disabled. The singular exception to this was when Petitioner attempted to attach a hitch to a truck on November 22, 2019. This isolated instance, which Petitioner stated caused him to experience pain, was not a basis upon which to terminate temporary total disability benefits. He was observed doing this on November 22, 2019, approximately seven weeks after benefits had been terminated. Further, Petitioner reported this issue to Dr. Raskas when seen by him on December 31, 2019, and it resulted in him having to sit down and rest for 30 minutes.

The only medical opinion Respondent has to base a termination of temporary total disability benefits is that of Dr. Crane and it is limited to Petitioner's neck/cervical spine condition. However, as noted herein, Petitioner has a number of other conditions, which, in and of themselves, would prevent Petitioner from returning to work. Petitioner was just seen by Dr. Davidson, an optometrist selected by Respondent, just two days prior to trial and she has continued to impose restrictions which prohibit Petitioner from returning to work as a commercial truck driver.

Given the preceding, the Arbitrator finds Respondent's termination of temporary total disability benefits to be unreasonable and vexatious and Section 19(k) penalties and Section 16 Attorneys' Fees are warranted.

Petitioner was temporarily totally disabled for 86 4/7 weeks, which at $659.12 per week equals $57,060.68. Respondent paid Petitioner temporary total disability benefits of $42,905.80, meaning the temporary total disability benefits owed to Petitioner are $14,154.88. The Arbitrator awards 19(k) penalties of 50% of the temporary total disability benefits owed, or $7,077.44.

The Arbitrator also awards Section 16 Attorneys' Fees of $1,415.49 (20% of $7,077.44).

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC013675
Case Name	WELLMAN,JACLYN v. CASE: GLENWOOD ACADEMY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0402
Number of Pages of Decision	57
Decision Issued By	Deborah Baker, Commisioner

Petitioner Attorney	David Menchetti
Respondent Attorney	Peter Stavropoulos

DATE FILED: 8/9/2021

/s/Deborah Baker, 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 Causal Connection, Medical, TTD, PPD	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACLYN WELLMAN,

Petitioner,

vs. NO: 13 WC 13675

CASE: GLENWOOD ACADEMY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of whether: the date of accident is correct, the benefit rates are correct, the wage calculations are correct, Petitioner's current condition of ill-being is causally connected to the accident, Petitioner is entitled to medical expenses both previously incurred and prospective, Petitioner's previously incurred medical treatment was reasonable and necessary, Petitioner is entitled to temporary disability benefits, Petitioner is entitled to permanent disability benefits, and "clerical errors," 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.

I. HISTORY & SUMMARY

Petitioner filed two claims alleging injuries while employed by Respondent: 13 WC 13675 (acute trauma on October 23, 2012); and 13 WC 13676 (acute trauma on March 19, 2013). Both matters were consolidated for hearing. At the hearing, the parties stipulated that both accidents arose out of and in the course of her employment with Respondent. The Arbitrator thereafter issued two separate decisions.

In case no. 13 WC 13675, the Arbitrator found Petitioner's perforated right eardrum and neck pain were causally related to the undisputed October 23, 2012 accident where a student punched Petitioner. The Arbitrator found further that Petitioner failed to prove she sustained a concussion, post-concussion syndrome, PTSD, TMJ, tinnitus, occipital neuralgia, anxiety, and migraines as a result of the October 23, 2012 accident. The Arbitrator found Respondent had paid all associated medical bills and thus awarded no medical benefits. The parties stipulated that temporary total disability ("TTD") benefits were not at issue in this case. The Arbitrator found Petitioner's injuries caused a 10% loss of the person-as-a-whole pursuant to section 8(d)(2) of the Act.

In case no. 13 WC 13676, the Arbitrator found Petitioner failed to prove she sustained a concussion, post-concussion syndrome, PTSD, TMJ, tinnitus, occipital neuralgia, anxiety, and migraines that were causally related to the undisputed March 19, 2013 accident where a student pushed and hit Petitioner for a second time. The Arbitrator found Petitioner's unspecified condition had resolved as of August 19, 2013 based on Dr. Landre's section 12 examination opinions and awarded medical and TTD benefits through August 19, 2013. The Arbitrator further found Petitioner's injuries caused a 7.5% loss of the person-as-a-whole pursuant to section 8(d)(2) of the Act. The Arbitrator noted the parties stipulated Respondent was entitled to a credit for TTD benefits and an advance in PPD benefits totaling $14,507.77.

The Commission agrees with the Arbitrator, in part, and finds Petitioner failed to prove that the TMJ, tinnitus, and occipital neuralgia conditions were caused by either the undisputed October 23, 2012 or the March 19, 2013 accidents. However, the Commission disagrees with the Arbitrator, in part, and finds Petitioner proved by a preponderance of the evidence that: (1) the undisputed accidents caused Petitioner to suffer concussions and post-concussion syndrome, which resolved by July 18, 2013; (2) the undisputed accidents aggravated Petitioner's migraines and resolved by July 18, 2013; (3) the undisputed accidents caused Petitioner to suffer PTSD, which resolved by September 20, 2016; and (4) the undisputed accidents aggravated and exacerbated Petitioner's anxiety and depression, which resolved by September 20, 2016.

II. ADDITIONAL FINDINGS OF FACT

In September 2007, Petitioner began working as a health assistant for Respondent, Cooperative Association for Special Education ("CASE")/Glenwood Academy. T. 10. Petitioner explained Glenwood Academy includes kindergarten through 12th grade, and all the students have a mental disability, physical disability, or behavioral problem. T. 13. Petitioner's job was to provide for the health needs of the students: she administered medication as needed; prepared health files for Individualized Education Plan meetings; and participated in daily or weekly meetings with each student and his/her social worker, psychologist, and physician. T. 11. She would accompany the students on certain field trips if medication issues made it necessary. T. 12. Petitioner is trained in Crisis Prevention and Intervention, and she assisted students who had trouble performing certain activities. T. 12. She was also a paraprofessional for the school, so she assisted students during physical education and helped in classrooms that were short-staffed. T. 12.

On August 23, 2010, Petitioner presented to her family physician, Dr. Sapan Patel at DuPage Medical Group's Wheaton Medical Clinic. Petitioner reported numbness and tingling in her left side face and arm for approximately three years. Petitioner also reported having severe headaches on the left side with blurry vision, anxiety when her migraines progressed, and fatigue. Dr. Patel diagnosed Petitioner with numbness and tingling, chronic left-sided headaches, and fatigue and recommended that Petitioner undergo an MRI of the brain to rule out a mass or other structural abnormality. Dr. Patel referred Petitioner to neurology for possible complex migraines. On August 30, 2010, Petitioner underwent an MRI of the brain which was within normal limits. Pet.'s Ex. 1; Pet.'s Ex. 12.

On April 16, 2012, Petitioner returned to Dr. Patel and reported that her migraines were getting worse over the last couple of months and she experienced facial numbness, blurry vision, tingling and sensory changes when she had severe migraines. Petitioner also reported a deep pain in the head that she had not experienced before. Dr. Patel noted that she had no focal abnormalities on a comprehensive neuro exam and diagnosed Petitioner with chronic migraines. Dr. Patel recommended Petitioner undergo a CT of the brain and blood work, and adjusted Petitioner's medication, opining that one medication may have been contributing to Petitioner's "rebound symptoms." Petitioner underwent the CT scan of the brain that same day, which was unremarkable. Pet.'s Ex. 12.

The October 23, 2012 Undisputed Accident

The parties stipulated that Petitioner sustained an accidental injury arising out of and occurring in the course of her employment on October 23, 2012. Arb.'s Ex. 1. Petitioner testified she was exiting a classroom in the elementary wing, having just administered medication to a student, when she encountered a classroom aide and another student in the hallway; the student was yelling that he had been punched by a fellow student, and the aide was walking him to Petitioner's office to get an ice pack. T. 14. Petitioner explained the protocol is that students in any kind of crisis are supposed to have three staff members with them, but the classroom aide left Petitioner alone with the student and "when I was asking him how did this happen, how he was hurt, he was yelling and swearing and then he started punching me." T. 14. Petitioner explained the student struck her with a fist using both hands. Petitioner also testified that the student punched her on the bridge of her nose, in the mouth, in the right ear, and jaw. Petitioner testified that she could not hear immediately after the student punched her in the ear. Petitioner testified further that she hit hear head on the wall and blacked out after being punched. T. 15. Petitioner testified the student was a first grader; he weighed 50 or 60 pounds and his height was below Petitioner's shoulder level. T. 15-16. Petitioner is 5'1" and she weighed approximately 110 pounds at that time. T. 16. Petitioner testified that she reported the incident. T. 16.

Petitioner sought medical care that day at DuPage Medical Group's Wheaton Medical Clinic where she was evaluated by Dr. Patel who had treated Petitioner previously. Pet.'s Ex. 12. Dr. Patel memorialized that Petitioner reported being punched in the face by a student, with blows landing on her forehead, nose, and right ear, and complained of ear pain and decreased hearing on the right side. Pet.'s Ex. 12. The doctor noted Petitioner denied vision changes and loss of consciousness. Pet.'s Ex. 12. Dr. Patel's physical examination revealed no large contusions to the head and facial bones stable to palpation, however the right tympanic membrane had a central

perforation. Pet.'s Ex. 12. Diagnosing a traumatic right ear perforation, Dr. Patel prescribed Cipro ear drops and referred Petitioner for evaluation by an ear, nose, and throat specialist. Pet.'s Ex. 12. At trial, Petitioner testified she continued working after the injury. T. 29.

On October 24, 2012, Petitioner was evaluated by Dr. Andrew Celmer, an otolaryngologist. Pet.'s Ex. 3. Dr. Celmer noted Petitioner had been referred by Dr. Patel for right tympanic membrane perforation. Pet.'s Ex. 3. Petitioner provided a consistent history of the altercation the day before followed by sudden ear pain and hearing loss; Petitioner also indicated she was struck in the nose and complained her nose was sore, but her breathing was unaffected. Pet.'s Ex. 3. Following an examination, Dr. Celmer diagnosed traumatic right ear perforation with conductive hearing loss as well as nasal trauma without evidence of fracture. Pet.'s Ex. 3. Dr. Celmer attempted a paper patch myringoplasty, but Petitioner could not tolerate the procedure so the doctor instead recommended dry ear precautions with the hope the tympanic membrane would heal on its own. Pet.'s Ex. 3.

That same day, Petitioner completed an Employee Report of Injury. Pet.'s Ex. 1. Therein, Petitioner memorialized that she was attempting to calm a student when he "punched me in the forehead, nose, and [right] temporal area/ear." Pet.'s Ex. 1. A witness statement prepared by Denise Polick reflects Petitioner was struck repeatedly in the nose and the ear area. Pet.'s Ex. 1.

On November 16, 2012, the incident was reported to the Glendale Heights Police Department. The report reflects Petitioner was punched three times in the nose and three times in the temporal/ear area. Pet.'s Ex. 1. The responding officer memorialized Petitioner wanted to document the incident but did not wish to pursue a complaint. Pet.'s Ex. 1.

On December 5, 2012, Petitioner was re-evaluated by Dr. Celmer, who noted dry ear precautions had been unsuccessful: there had been no closure of the perforation and Petitioner had persistent hearing loss and right ear pain. Concluding Petitioner likely required formal tympanoplasty, Dr. Celmer referred Petitioner to Dr. Griffith Hsu for an otology consultation. Pet.'s Ex. 3.

At trial, Petitioner testified that in the weeks after her accident, in addition to her ear symptoms, she also had pain in her teeth and jaw. T. 18. Pursuant to a referral from Dr. Ismail, Petitioner consulted with Gregory Doerfler, D.D.S., on December 14, 2012. T. 18. Dr. Doerfler noted Petitioner complained of pain with function as well as "popping" on the right side after being struck three times in the right side of the face; Petitioner did not lose consciousness but did slide to the floor, and over the next hours, her jaw stiffened up. Cone-bean CT dental imaging was completed and was negative for significant osseous or soft-tissue abnormality, and Dr. Doerfler indicated further imaging should be considered. Pet.'s Ex. 11.

On December 18, 2012, Petitioner was evaluated by Dr. Hsu. Upon examining Petitioner's tympanic membrane perforation and conducting an audiogram and tympanogram, Dr. Hsu recommended proceeding with tympanoplasty. Pet.'s Ex. 13. On January 7, 2013, Dr. Hsu performed a right tympanoplasty and right allograft reconstruction. Pet.'s Ex. 13. Post-operatively, Petitioner attended routine follow-up appointments with Dr. Hsu.

On February 11, 2013, Petitioner was evaluated pursuant to §12 by Dr. Sam Marzo. T. 28-29. Petitioner gave a history of being hit in the head with a fist multiple times in October 2012. She was thereafter diagnosed with a perforated tympanic membrane and underwent a tympanoplasty in January. She advised she was recently seen by a neurologist who diagnosed post-concussive syndrome as well as occipital neuralgia and performed a nerve block, and Petitioner had further been told she has TMJ. Upon examination and hearing tests, Dr. Marzo's diagnoses included central perforation of tympanic membrane; post-concussion syndrome; conductive hearing loss, tympanic membrane; subjective tinnitus; otogenic pain; ear pressure; and temporomandibular joint disorders, unspecified. Dr. Marzo noted Petitioner's right ear appeared to be healing nicely and recommended she undergo an audiogram as soon as it healed completely. The doctor observed Petitioner's pain and tinnitus should improve with time. Dr. Marzo further recommended Petitioner continue TMJ treatment as well as neurologic management of her post-concussive syndrome. Pet.'s Ex. 16.

At the March 7, 2013 follow-up with Dr. Hsu, Petitioner indicated she continued to experience muffled hearing. On examination, Dr. Hsu observed Petitioner's tympanic membrane was intact; an audiogram revealed Petitioner's right conductive hearing loss had resolved. Dr. Hsu released Petitioner from care. Pet.'s Ex. 13.

That same day, March 7, 2013, Dr. Karen Levine performed a neurological evaluation of Petitioner at Respondent's request. The record reflects Dr. Levine opined Petitioner's pre-existing migraines could have been aggravated by the work injury, and the doctor recommended further workup with an MRI; Dr. Levine's diagnosis was mild post-concussion syndrome. Resp.'s Ex. 4.

The March 19, 2013 Undisputed Accident

The parties stipulated that Petitioner sustained a second accidental injury arising out of and occurring in the course of her employment on March 19, 2013. Arb.'s Ex. 2. Petitioner testified she was attacked while in an elementary classroom to administer medication:

> And I went to one student to give him his medication; and I bent down to give it to him and another thought that it was his turn for medication and it was not, so he got angry and was yelling and swearing at me and he ran out of the classroom. So the classroom assistant ran out after him and I could not leave the room with the other students in it, they can't be alone. So I finished what I was doing with the other students and their medication, and the student that ran out of the room came back in the room running and swearing at me. And my back was to the area he was coming from. He punched me in the middle of my back, jumped on my back, started punching me in the neck and in my head, the back of my head. And I tried to get him off me and he kept punching me, and I hit the wall in the front and blacked out and had to have somebody walk me to my office. I couldn't walk straight. T. 21-22.

The student was eight years old and weighed 60 or 70 pounds; he punched Petitioner with both fists. T. 22. Petitioner explained her forehead and face hit the wall before she blacked out. T. 22.

Petitioner sought treatment that day at the Central DuPage Hospital emergency room where she was seen by Kerri Manning, PA-C, and Joseph Boyle, D.O. The records reflect Petitioner presented with a chief complaint of concussion and provided the following history:

> The patient is a 35-year-old female who comes in today after an injury at work. The patient in October was punched by a student at an alternative school, where she works at and sustained a pretty significant concussion with a ruptured tympanic membrane. She supposedly suffers from postconcussive syndrome and has been under the care of Dr. Cheng of neurology. She continues to have headaches and some occipital neuralgia. The patient has been back at work and today was hit from behind by a student and punched in the occiput. Has worsening head pain and dizziness as well as nausea at this time. There is no loss of consciousness, no numbness, tingling, or weakness anywhere. The patient took Fioricet with no relief of her pain. Pet.'s Ex. 15.

Examination findings included normocephalic and atraumatic head; pupils equal, round, and reactive to light; and Petitioner was alert and oriented to person, place, and time with normal mood and affect. After diagnostic workup, Dr. Boyle's impression was as follows:

> Pt with neg. CT. Pt with new concussion. Unfortunately, the pt. Has [*sic*] post-concussive syndrome from a head injury a few months ago. Pt seems to be suffering from PTSD from first concussion. Pt met with social worker who assisted with f/u for this pt. Pt given new neurologist as well. Pet.'s Ex. 15.

Petitioner was authorized off work for the remainder of the week and discharged with instructions to follow-up with her primary care physician. Pet.'s Ex. 15. Petitioner testified she has not worked since the March 19, 2013 accident. T. 30.

The next day, March 20, 2013, Petitioner completed an Employee's Report of Injury. Petitioner memorialized that a student ran into the classroom "and pushed me in the back and hit the back of my head, my head whipped back," and identified injuries to her head, neck, back, and another concussion. Pet.'s Ex. 1.

Petitioner testified that while she was under the care of Dr. Cheng, she underwent some injections. Ultimately, however, Dr. Cheng referred her to Marianjoy for further evaluation and treatment with a brain injury specialist. T. 24.

On April 11, 2013, Petitioner consulted with Dr. Sachin Mehta at Marianjoy Medical Group. The records reflect Petitioner's chief complaint was post-concussion neuro behavioral deficit, neuro cognitive deficit, impaired balance, visual spatial, headache, and insomnia. The two work injuries were detailed in the history of illness and Petitioner's current symptoms were as follows:

> She [complains of] TROUBLE WITH "FLIPPING LETTERS, NUMBERS, DIRECTIONS", CALCULATING DIFFICULTIES. HER HUSBAND NOTED THAT SHE WROTE "NAVERPILE INSTEAD OF NAPERVILLE." SHE

> STATES SHE IS MORE IRRITABLE, LESS TOLERANT OF HER KIDS [*sic*] ACTIONS. SHE [CONTINUES TO COMPLAIN OF] CONSTANT [HEADACHES] AND [BILATERAL] EYE TWITCHING. SHE RECEIVED AN [RIGHT] OCCIPITAL NERVE BLOCK BY DR. CHANG [*sic*] WHICH IMPROVED THE [RIGHT] EYE TWITCHING BUT ONLY HELPED [HEADACHE] FOR 3-4 DAYS.
> HER MOOD IS DOWN. SHE FEELS NERVOUS AND ANXIOUS. SHE STATES SHE HAS BEEN TOLD SHE HAS PTSD. SHE [COMPLAINS OF] FEELING FATIGUED MOST OF THE DAY AS WELL AS JITTERY. APPETITE IS POOR AND SHE MUST FORCE HERSELF TO EAT BUT THEN DEVELOPS NAUSEA.
> SHE FEELS LOSS OF CONTROL OVER HER LIFE. IN ADDITION TO WORKING 37 HOURS/WEEK, SHE WAS ALSO ATTENDING CLASSES 2-6 HOURS/WEEK. HER HUSBAND IS ON DISABILITY AND CANNOT WORK OR HELP MUCH RUN THE HOUSE. SHE IS THE PRIMARY CAREGIVER FOR HER CHILDREN. Pet.'s Ex. 8 (Emphasis in original).

The Post-Concussion Physical Exam findings included tenderness to the neck/upper back and right occipital nerve, decreased neck range of motion, slow and guarded gait, abnormal balance, and mild convergence deficits; cognition findings included recent and remote memory intact, lethargy, anxiety, depression, and flat affect. Petitioner was noted to be anxious and tearful throughout the examination. Dr. Mehta's assessment was post-concussion syndrome, neurobehavioral deficits/neurocognitive, impaired balance, insomnia, anxiety/depression/PTSD, and chronic post-concussion headaches. The treatment recommendation was multifaceted. For the post-concussion syndrome, Dr. Mehta recommended enrollment in the post-concussion day rehab program with therapy for vestibular dysfunction, visual-spatial deficits, and neurocognitive deficits; a neuropsychology evaluation prior to initiating therapy to assist with coping and validity assessment; and a neuro-optometry evaluation for visual-spatial deficits. Noting Petitioner had a pre-existing history of mild depression likely exacerbated by multiple assaults/concussions, Dr. Mehta referred Petitioner to Dr. Jordania, a neuropsychiatrist, and to neuropsychology to address Petitioner's depression/anxiety. Dr. Mehta prescribed Nortriptyline, Xanax, and Melatonin for Petitioner's insomnia; Ritalin for her daytime fatigue; and Nortriptyline and Fioricet for headaches. Finally, Dr. Mehta authorized Petitioner off work and directed her not to drive. Pet.'s Ex. 8.

On April 15, 2013, Petitioner presented to the Glen Oaks Hospital emergency room complaining of an onset of left paresthesia and altered speech 20 minutes prior. Dr. Daniel O'Reilly consulted and noted Petitioner had developed a right-sided headache followed shortly thereafter by numbness on the left side of her tongue and lip with some slurred speech and then developed numbness in her left arm and her left leg. It was further noted Petitioner had a prior history of being punched in the face with brief loss of consciousness in October as well as a second assault in March, and she was in treatment for post-concussion syndrome, which she described as headache which was constant since October, frequent nausea, postural dizziness, and difficulty with her balance. Petitioner was worked up for possible stroke with a CT and MRI of the head/brain; when the testing was negative for TIA, Petitioner was discharged with instructions to follow-up with her neurologist and primary care physician. Pet.'s Ex. 14.

On April 22, 2013, Dr. Nina Jordania performed an initial psychiatric evaluation of Petitioner as recommended by Dr. Mehta. The record reflects Petitioner reported headaches with photo and phonophobia, jumpiness and nervousness, and feeling very anxious and fearful dating back to her first concussion. Petitioner also reported poor balance, difficulty focusing, fear of being alone with strangers, nightmares, constantly rewinding the events, hypervigilance, as well as multiple somatic symptoms. Dr. Jordania's assessment was anxiety due to medical condition (post-concussive syndrome) and PTSD, insomnia due to PTSD, and post-concussive syndrome. Dr. Jordania discussed psychoeducation strategies and adjusted Petitioner's medications. Pet.'s Ex. 6.

In late April and early May, Respondent conducted surveillance of Petitioner. The Commission has reviewed the video offered into evidence as Respondent's Exhibit. 6.

On April 30, 2013, Petitioner commenced therapy through Marianjoy's day rehab program. Over the next several weeks, Petitioner attended approximately twice weekly occupational, physical, and speech therapy. Pet.'s Ex. 7.

At the May 16, 2013 follow-up appointment with Dr. Mehta, Petitioner reported she was making progress with therapy; she continued to have constant right-sided headache but was learning strategies to manage the pain. Dr. Mehta noted the therapy staff reported Petitioner's headaches were slightly improved, her overall balance was better, her tolerance for eye movements was improved, and she had improved attention and executive functioning, especially with structured tasks with breaks. Dr. Mehta further noted Petitioner underwent a neuropsychological evaluation with Dr. Devereux, and Petitioner indicated there were problems with computer color, which could affect Petitioner's performance. Dr. Mehta spoke with Dr. Devereaux, who indicated Petitioner performed on the test as poorly as someone who has Alzheimer's although she does not function in her daily life as someone who does have Alzheimer's disease. Dr. Mehta adjusted Petitioner's Ritalin dosing and directed Petitioner to continue with the comprehensive day rehab program as well as follow-up with Dr. Jordania. Pet.'s Ex. 8.

Over the next weeks, Petitioner underwent further therapy at Marianjoy and also saw Dr. Jordania, who adjusted Petitioner's medication. Pet.'s Ex. 6.

On June 6, 2013, Petitioner presented to Dr. Hsu; the record reflects Dr. Celmer requested the consultation to evaluate Petitioner's complaints of balance problems, ringing in both ears, and decreased hearing on the right. A hearing assessment was performed and revealed a slight decrease to thresholds compared to the March 17, 2013 assessment. Dr. Hsu's assessment was tinnitus most likely secondary to concussion and unspecified hearing loss. Petitioner was directed to return if her symptoms failed to improve. Pet.'s Ex. 13.

Petitioner was discharged from speech therapy on June 13, 2013. The speech language pathologist documented Petitioner demonstrated independent use of strategies. Pet.'s Ex. 7. The next day, June 14, Petitioner was discharged from occupational therapy. The discharge summary reflects Petitioner had achieved all therapy goals but had remaining impairments and limitations:

> [Patient] with good progress in OT meeting all goals set at evaluation. Patient has demonstrated a steady improvement in her ability to return to IADL and community

> level tasks by implementing strategies learned in OT to reduce stimulation and reduce exacerbation of post concussive symptoms. [Patient] demonstrates improved ocularmotor function with only mild impairment with movements to outer areas of the visual field only rarely. Patient is now able to turn her eyes and head to see her full environment without increased symptoms during her sessions in the clinic. Patient still fatigues more quickly than baseline but with good planning she can manage this to maximize her productivity. Her area of greatest limitation is still in navigating a large, busy area in the community for tasks that require greater amounts of visual scanning and locating items such as during grocery shopping. [Patient] also does still have headache pain although it is more manageable at a 4/10 or less most times. Pet.'s Ex. 7.

On June 21, 2013, Petitioner underwent a driver rehabilitation evaluation at Marianjoy. The occupational therapist opined Petitioner demonstrated the necessary skills for independent driving and no further sessions were indicated. Pet.'s Ex. 5, Pet.'s Ex. 7.

Petitioner was re-evaluated by Dr. Mehta on July 2, 2013. Dr. Mehta noted Petitioner completed the day rehab program and transitioned to a home exercise program; it was further noted Petitioner finished seeing Dr. Devereux who diagnosed Petitioner with PTSD. Dr. Mehta concluded Petitioner was steadily improving from a concussion standpoint but continued to have significant PTSD symptoms. Dr. Mehta recommended Petitioner continue seeing Dr. Jordania for medical management of her PTSD and also referred her to a psychologist specializing in post-traumatic stress counseling. Pet.'s Ex. 5, Pet's Ex. 8.

At the July 18, 2013 follow-up appointment with Dr. Jordania, Petitioner reported significant improvement in her headaches, but her PTSD was still very symptomatic. She described persistent fear of children and people in public places as well as fear of being attacked. Dr. Jordania diagnosed anxiety due to medical condition (post-concussive syndrome), PTSD, and insomnia due to PTSD, and adjusted Petitioner's medications. Pet.'s Ex. 6. On July 23, Dr. Jordania authored a letter indicating Petitioner was unable to work due to post-concussion symptoms. Pet.'s Ex. 5.

Pursuant to Dr. Mehta's referral, Petitioner sought treatment at Pathways Psychology Services; the initial consultation with Steve Cromer, L.C.P.C., took place on July 31, 2013. Diagnosing PTSD and concussions - beat up at work, Cromer recommended individual therapy to address Petitioner's PTSD and fear/anxiety. Pet.'s Ex. 5. Petitioner attended therapy sessions with Cromer for the next several months. Pet.'s Ex. 5.

On August 19, 2013, Dr. Nancy Landre performed a neuropsychological evaluation pursuant to §12 at Respondent's request. Dr. Landre's report reflects Petitioner's performance on the symptom validity assessment was abnormal, indicating the cognitive test results were not valid for interpretation as they likely portrayed her as much more impaired than she was. Dr. Landre noted Petitioner's level of performance on some standard cognitive indices was improbably low, at a level typically seen in patients with severe brain injuries or advanced dementia. Dr. Landre concluded as follows: "Available evidence, therefore, suggest that factors other than the injury itself underlie Ms. Wellman's continued complaints. Petitioner is capable of resuming full-time

work activity without any restrictions at this time. No further recommended treatment." Resp.'s Ex. 1.

A week later, on August 26, 2013, Dr. Mehta authored a note indicating Petitioner remained under his care for post-concussive syndrome complicated by post-traumatic stress symptoms and was unable to return to work. Pet.'s Ex. 5.

Over the next two months, Petitioner remained off work and attended counseling sessions with Cromer and follow-up appointments with Dr. Mehta and Dr. Jordania. At the November 4, 2013 re-evaluation with Dr. Mehta, Petitioner reported continuing difficulties with headaches, dizziness with certain movements, and anxiety; Petitioner described experiencing agoraphobia, flashbacks, and trouble sleeping, with occasional nightmares. Petitioner advised the doctor that she hoped to return to work but was unable to go back to her previous job, and she inquired about other options. Dr. Mehta directed Petitioner to continue seeing Dr. Jordania and her counselor, and ordered a vocational assessment:

> We did write an order for vocational counseling to assess her current condition. She is unable to return to her previous job. I would like her to have some idea as to other options that she can tolerate. She has significant PTSD, which may prevent her from returning to the previous job. She also continues to have some neurobehavioral, neurocognitive deficits at this time. Therefore any type of return to work, she would need a full neuropsychology battery. Pet.'s Ex. 8.

The doctor further documented he was leaving Marianjoy, and Petitioner's care would thereafter be overseen by Dr. Sayyad. Pet.'s Ex. 8.

On November 11, 2013, Petitioner met with Ken Skord, M.S., C.R.C., for a vocational rehabilitation consultation. Skord documented Petitioner's vocational history included EMT certification, certified phlebotomist, CNA, certification to perform school vision and hearing screenings, and licensed cosmetologist; Petitioner additionally had paramedic training and had nearly completed an AA degree in science. Pet.'s Ex. 7. Vocational barriers were identified as post-traumatic stress disorder, ruptured eardrum, hand tremors, migraine headaches, jaw problems, eye problems, depression, and anxiety. Petitioner reported she wished to work again but expressed significant fears and concerns about returning to work to her current employer or similar work. She indicated she was contemplating applying for a part-time position as a breast-feeding counselor assisting women who want and need training, as she has interest and previous training in this area. Skord encouraged Petitioner to contact him if she wished to pursue formal vocational evaluation and counseling and provided her with a resource for finding volunteer opportunities. Pet.'s Ex. 7.

Follow-up appointments with Dr. Jordania and counseling sessions with Cromer continued through the end of 2013 and into 2014. On January 30, 2014, Petitioner presented for an initial evaluation with Dr. Anjum Sayyad. Dr. Sayyad noted Petitioner's past medical history was significant for post-concussive syndrome with posttraumatic stress disorder, associated with neurobehavioral deficits. Petitioner recently had her Ritalin increased and reported improvement in her attention and concentration; however, she continued to have poor sleep, light and sound

sensitivity, hypervigilance, memory problems, and dizziness with position changes. Dr. Sayyad's impression was ADL mobility dysfunction with neurocognitive and neurobehavioral deficits associated with post concussive syndrome and PTSD. The doctor recommended continued treatment with Dr. Jordania and authorized Petitioner to remain off work. Pet.'s Ex. 4.

Over the next several months, Petitioner underwent regular counseling with Cromer and attended routine follow-up appointments with Dr. Jordania and Dr. Sayyad. Pet.'s Ex. 5, Pet.'s Ex. 6, Pet.'s Ex. 7. In May 2014, Petitioner reported she completed two classes but did not feel that she did well. Dr. Sayyad's nurse practitioner, Sylvia Duraski, APN, encouraged Petitioner to take another class, indicating speech therapy could be ordered to assist with Petitioner's attention and memory deficits. When Petitioner followed up on September 4, 2014, she reported she had taken additional classes but failed both; APN Duraski directed Petitioner to continue treatment with Dr. Jordania and counseling with Cromer, and also ordered speech therapy to help Petitioner in her classes. Petitioner was to remain off work and neuropsychological testing was ordered to assess whether Petitioner was ready to return to work. Pet.'s Ex. 4, Pet.'s Ex. 8.

The recommended therapy evaluation took place on November 13, 2014. The therapist concluded Petitioner required skilled speech language pathology services to facilitate functional cognitive communication skills to enable safety and independence with daily tasks and responsibilities at home, in the community, and at work. A course of three sessions per week for four to six weeks was recommended. Pet.'s Ex. 7. Petitioner started therapy on November 25, 2014 and continued through the end of the year.

On December 31, 2014, Dr. Alexander Obolsky issued a report summarizing the psychiatric examination of Petitioner he conducted pursuant to §12 at Respondent's request. Petitioner had undergone testing at Dr. Obolsky's direction on April 29, 2014 and met with him on May 16, 2014. Dr. Obolsky concluded Petitioner exhibited malingering as well as avoidant, dependent, and compulsive personality features. Dr. Obolsky opined there was no objective evidence that Petitioner's "alleged work events caused clinically significant mental, emotional, or cognitive dysfunction." Resp.'s Ex. 3. The doctor indicated that during the forensic psychiatric evaluation, Petitioner did not present with behavioral symptoms of anxiety, distress, or avoidance when describing the alleged traumatic events, and she had no difficulties with recall, describing events in detail, and showed neither anxiety nor hyperarousal when recalling and discussing these events. In contrast, on the medical psychiatric questionnaire, she endorsed over 40 current assorted symptoms involving various bodily symptoms, and on forensic psychological testing, Petitioner exaggerated somatic and cognitive complaints and inconsistently magnified psychiatric symptoms. Dr. Obolsky opined Petitioner's observed behaviors during the two days of the evaluation were incongruent with her self-reported subjective complaints. Dr. Obolsky further felt Petitioner's self-report of subjective symptoms was unreliable due to her reporting inauthentic, exaggerated, and inconsistent symptoms. Dr. Obolsky opined Petitioner had been exaggerating her various mental, emotional, and cognitive complaints "as far back as several weeks after the alleged second injury." Resp.'s Ex. 3. Dr. Obolsky believed Petitioner exhibited "life-long maladaptive avoidant, dependent, and obsessive-compulsive personality features." Resp.'s Ex. 3. Dr. Obolsky concluded as follows:

> …Ms. Wellman reports multiple and various subjective mental, emotional, and cognitive symptoms. Her self-report is unreliable as evidenced by exaggeration of

> symptoms, inconsistencies, and discrepancies noted above. There is no objective evidence to support presence of reported symptoms and the alleged causal connection of such symptoms to the work events in 2012 and 2013. On the other hand, Ms. Wellman exhibits a life-long personality features [*sic*] that interfere with her interpersonal functioning leading to dysthymia, anxiety, worries, fears, and somatic complaints. Ms. Wellman has decided not to return to her employment, she is claiming mental, emotional, and cognitive symptoms as justification for remaining off work. Resp.'s Ex. 3.

Dr. Obolsky further concluded Petitioner did not develop post-traumatic stress disorder due to the work events. Resp.'s Ex. 3.

Follow-up treatment with Dr. Jordania and Dr. Sayyad and counseling with Cromer continued into 2015. On April 21, 2015, Petitioner was re-evaluated by Dr. Jordania. Dr. Jordania memorialized that upon Petitioner's initial presentation, Petitioner's symptom complex included problems with sleep, constant headaches with photo and phonophobia, nervousness, heightened anxiety, inability to focus, memory difficulties, nightmares, fear of everything, ringing in her ears, vision problems, and inability to drive due to poor balance. Petitioner's current symptoms were noted to be headaches with increasing sensitivity to different stimuli as the day progresses, persistent ringing in the ears, improved palpitations, and continuing jumpiness but without automatically assuming that it is a bad thing. The doctor observed Petitioner was "very disturbed by the review of independent Neuropsychological evaluation concluding that her presentation and symptoms do not meet the criteria of PTSD not postconcussive syndrome, diagnosing her with Malingering and Somatization." Pet.'s Ex. 6. Upon discussing Petitioner's cognitive and mood status, Dr. Jordania concluded Petitioner had "achieved MMI with the present medication regimen." Pet.'s Ex. 6. Dr. Jordania's assessment remained anxiety due to medical condition (post-concussive syndrome), PTSD, and insomnia due to PTSD; the treatment plan was to "keep her meds as is and add amantadine." Pet.'s Ex. 6.

On July 7, 2015, Petitioner followed up at Marianjoy. The record reflects Petitioner's symptoms were unchanged. Pet.'s Ex. 4.

In early 2016, Respondent obtained a labor market survey. Resp.'s Ex. 5. The February 29, 2016 report indicates appropriate vocational goals for Petitioner include claims clerk, receptionist, collections clerk, hospital-admitting clerk, radio dispatcher, administrative clerk, customer service clerk, home attendant, and teacher aide. The wage range for those positions within a 50-mile radius was $12.00 to $23.00 per hour. Resp.'s Ex. 5.

Petitioner's next follow-up visit at Marianjoy occurred on March 25, 2016. Petitioner reported her headaches were under control since Dr. Jordania increased her Depakote dose; Petitioner continued to get headaches but they did not occur until evening, though the side effect of Depakote was Petitioner got tired in the afternoon. Petitioner further advised she recently resumed taking classes and was enrolled in a criminal investigation class as well as a grief therapy class; she reported the grief class was helping with her PTSD. After discussion with Dr. Sayyad, Petitioner was advised to try a small dose of Amanatadine to address her fatigue. She was

otherwise to continue with the treatment plan of ongoing follow up with Dr. Jordania and the psychologist. Pet.'s Ex. 4, Pet.'s Ex. 8.

On May 18, 2016, Petitioner saw Dr. Jordania for the last time; the record reflects the doctor advised Petitioner that she would be moving from the area. Dr. Jordania reiterated that Petitioner remained at maximum medical improvement with her present medication regimen, and discussed transitioning her care to another psychiatrist. Pet.'s Ex. 6.

The last medical visit in the record is the September 20, 2016 follow-up at Marianjoy. Petitioner reported she started taking Amantadine as directed at the last visit and was much less tired during the day. She further advised headaches on the right side of her head had returned, her blood pressure was slowly climbing, and she was still looking for a psychiatrist to replace Dr. Jordania. Petitioner reported that she was doing well in her classes and was taking more counseling classes. The diagnoses on that date included post-concussion syndrome; major depressive disorder, single episode, unspecified; posttraumatic stress disorder; posttraumatic headache, unspecified, not intractable; insomnia, unspecified; and other symptoms and signs involving cognitive functions. Dr. Sayyad's nurse practitioner provided names of potential psychiatrists, adjusted Petitioner's Ritalin dose, encouraged Petitioner to continue taking classes, and directed Petitioner to remain off work. Pet.'s Ex. 4, Pet.'s Ex. 8.

At trial, Petitioner described what she experienced from April 2013 to 2018. Petitioner testified her vision and hearing were getting worse, balance was a problem, lights and noises would cause ringing in her ears, and she became dizzy if she moved too fast. T. 27. There was a period where she could not drive because she had diminished peripheral vision and depth perception in her left eye. T. 27-28. Prior to her initial work accident, Petitioner exercised on a regular basis, did not take medication for any reason, and could sleep, go running, use the stethoscope properly, and see properly. T. 29.

Petitioner testified she returned to school at College of DuPage in 2017 and completed an Associate Degree in Applied Science in Human Services for Addictions Counseling in May 2019. T. 31-32. Petitioner described her time in college as difficult: "I had some roadblocks to try to complete it. I had a lot of help with my professors and counselors and advisors at COD to help me through. Marianjoy had given me an order for accommodations while I was in school." T. 32. Petitioner explained her accommodations included extra testing time, extra time for work, and a private area to feel safe studying. T. 32. Petitioner had trouble "flipping numbers around" and problems comprehending what she was reading. T. 33.

Petitioner described her current difficulties. She has problems sleeping and has nightmares about "these issues occasionally." T. 36. She gets dizzy and can lose her balance if she stands too quickly from a seated position. T. 36. She experiences loud ringing in her ears when she gets anxious, which causes her to get "light-headed." T. 36. She is sensitive to bright lights and she gets nervous around a lot of people "in newer situations." T. 36. She becomes anxious in public. T. 37. She uses landmarks to remember where she parked her car because she has difficulty remembering things when she gets nervous. T. 38. Petitioner takes multiple prescription medications: Lamictal for migraines, Lexapro for depression, Buspar for anxiety, Ritalin for concentration, and potassium to counteract cardiac side effects of her other medications. T. 35.

Depositions

The March 1, 2017 evidence deposition of Dr. Anjum Sayyad was admitted as Petitioner's Exhibit 10. Dr. Sayyad is board-certified in brain injury medicine as well as physical medicine and rehabilitation. Pet.'s Ex. 10, p. 5-6. Dr. Sayyad is the residency director of the physical medicine and rehabilitation medical residency program at Marianjoy Rehabilitation Hospital and is a former medical director of Marianjoy's inpatient and day rehabilitation brain injury program. Pet.'s Ex. 10, Dep. Ex. 1.

Dr. Sayyad testified she assumed Petitioner's care when Dr. Mehta left the practice; Dr. Sayyad reviewed Dr. Mehta's treatment notes prior to seeing Petitioner. Pet.'s. Ex. 10, p. 10. Dr. Sayyad first evaluated Petitioner on January 30, 2014; this was in connection with Dr. Sayyad's role as medical director of Marianjoy's Brain Injury Program. Pet.'s. Ex. 10, p. 9. At that initial evaluation, Petitioner complained of problems with concentration, headaches, and problems with sleep. Pet.'s. Ex. 10, p. 10-11. Petitioner reported Dr. Jordania was managing her medication, and her current Ritalin regimen helped her attention and concentration difficulties. Pet.'s. Ex. 10, p. 11. Petitioner further advised she was taking online classes and was also undergoing vocational rehabilitation counseling with a goal of returning to work when she was better able to perform on the cognitive tests; Dr. Sayyad explained Petitioner "was very sensitive to light and sound and was hyper-vigilant, which would be consistent with her diagnosis of PTSD." Pet.'s. Ex. 10, p. 12. Dr. Sayyad performed a physical examination and observed findings of anxiety and depression as well as a flat affect. Pet.'s. Ex. 10, p. 13. Dr. Sayyad authorized Petitioner off work and recommended she follow up with Dr. Jordania for medication management of her post-concussion neurocognitive issues with attention and concentration. Pet.'s. Ex. 10, p. 14-15.

Dr. Sayyad continued to see Petitioner every three to four months until September 2016. Pet.'s. Ex. 10, p. 17. Dr. Sayyad summarized Petitioner's treatment over that period:

> But in short, she continued to have significant amounts of anxiety, where she for a few visits continued to exhibit picking at her scalp, having problems with attention and concentration. We would occasionally make changes in some of those medications, but her anxiety was such that sometimes she could not incorporate the changes we'd recommend. One example was we had recommended trialing Inderal, which can be very helpful for headache pain and for anxiety, but she was so concerned about blood pressure changes, she couldn't really make herself take the medicine or fill the prescription. It would take a couple of visits to kind of convince her to follow through on some of the treatment because of her anxiety being so great. By the time I saw her in her last visit, September 20th of 2016, she started to show some signs of some improvement. She was taking new medicines at that point to help with her attention and focus. She continued to have headaches. They would wax and wane throughout these visits. She still had one by the last visit. She was tolerating the Ritalin. And she was, at one point, as you recall, she was seeing Dr. Jordania, but Dr. Jordania had moved to Florida so she didn't have a psychiatrist to follow-up with and was trying to identify one at that point. And she was doing a little bit better in her classes by the last visit that I saw her. Pet.'s. Ex. 10, p. 17-19.

Directed to the September 20, 2016 visit, Dr. Sayyad testified that the progress note indicated Petitioner had a much brighter affect, was smiling and appeared more optimistic on examination. Pet.'s. Ex. 10, p. 19. The assessment was post-concussion syndrome, major depressive disorder, post-traumatic stress disorder, post-traumatic headache, insomnia, and signs and symptoms involving cognitive function. Pet.'s. Ex. 10, p. 20. The treatment plan was for Petitioner to find a new psychiatrist as soon as possible, increase her Ritalin dose to combat her headaches, and Petitioner was also encouraged to continue with school. Pet.'s. Ex. 10, p. 20-21. Dr. Sayyad opined Petitioner was not yet ready to return to work as of September 20, 2016 because she had not stabilized: Petitioner was doing better in some areas, but she still had headache symptoms and her medications were being adjusted. Pet.'s. Ex. 10, p. 26-27. Dr. Sayyad clarified that her nurse practitioner, Sylvia Duraski, APN, saw Petitioner on September 20, 2016, and Dr. Sayyad thereafter discussed the case with her and signed off on the chart note. Pet.'s. Ex. 10, p. 22.

Dr. Sayyad testified that Dr. Mehta had diagnosed Petitioner with post-concussion syndrome, PTSD, neurocognitive deficits associated with the PTSD and post-concussion syndrome, and post-traumatic headache. Pet.'s. Ex. 10, p. 24. Dr. Sayyad agreed with that diagnosis and she had carried it forward as she treated Petitioner over the next three years. Pet.'s. Ex. 10, p. 24. Turning to causation, Dr. Sayyad concluded "there is a connection between Ms. Wellman being punched in the head by a student and these diagnoses." Pet.'s. Ex. 10, p. 25.

On cross-examination, Dr. Sayyad agreed she ordered neuropsychological testing on January 6, 2015; the doctor explained she ordered the testing so "we could track what her - - objectively what the difficulties she was having with her attention and concentration issue that she was reporting difficulty. It also helps us determine a baseline from which we can compare either future or past results with." Pet.'s. Ex. 10, p. 30. Dr. Sayyad confirmed the testing would also identify areas of weakness and assess whether Petitioner was ready to return to work. Pet.'s. Ex. 10, p. 30. Dr. Sayyad testified that January 6, 2015 was the last time she saw Petitioner; the remaining visits were conducted by her nurse practitioner and discussed with the doctor afterwards. Pet.'s. Ex. 10, p. 33. Dr. Sayyad did not have a record of the testing being completed and she had not reviewed any neuropsychological testing results. Pet.'s. Ex. 10, p. 29. Dr. Sayyad agreed that absent this testing there is no objective basis for work restrictions. Pet.'s. Ex. 10, p. 33.

The March 9, 2017 evidence deposition of Dr. Nancy Landre was admitted as Respondent's Exhibit 2. Dr. Landre is a board-certified clinical psychologist with specialty training in neuropsychology. Resp.'s Ex. 2, p. 5. Dr. Landre sees a variety of patients for dementia, learning disabilities, ADHD, head injuries, and other neurological disorders such as stroke and MS. Resp.'s Ex. 2, p. 5. She does both treatment and legal evaluation. Resp.'s Ex. 2, p. 5. Dr. Landre was formerly the clinical neuropsychologist for the traumatic brain injury program at Lutheran General Hospital. Resp.'s Ex. 2, p. 6.

At Respondent's request, Dr. Landre performed a neurological evaluation of Petitioner on August 19, 2013. Resp.'s Ex. 2, p. 8. The doctor explained her evaluation process:

> …I receive the records ahead of time, and I would glance at those and just get an overview of what's going on with the case. And then the patient would come in. I would meet with them first for a clinical interview that normally lasts between an

> hour to an hour and a half, during which time I would get information about their injury, their medical history, their academic history, their work history, current lifestyle, things of that nature. And then I would decide what tests I would like to have the patient be administered as part of the evaluation. So I would indicate that and give the test battery to my technician. And my technician would then take over at that point and do all of the testing with the patient. Then they score everything out, they give it back to me. I look over the test results and I would write a report and interpret them and then write a report based on my interpretation. Resp.'s Ex. 2, p. 9-10.

The battery of testing that Petitioner underwent takes between four and five hours depending on how quickly the patient works. Resp.'s Ex. 2, p. 10.

Directed to her August 19, 2013 report, Dr. Landre testified she took a history from Petitioner and reviewed outside records, and the history within the report is a combination of the two. Resp.'s Ex. 2, p. 10-11. Dr. Landre testified consistent with her report.

Dr. Landre testified the testing Petitioner underwent includes performance validity and symptom validity measures designed to ensure the patient is giving his/her best effort and to identify over-reporting of symptoms. Resp.'s Ex. 2, p. 22-24. Dr. Landre testified Petitioner failed "a bunch of those," which tells the clinician that "the patient profile is likely very exaggerated and probably is portraying her as more distressed or dysfunctional from a mental health cognitive or somatic standpoint than is actually the case." Resp.'s Ex. 2, p. 24-25. Dr. Landre explained that, based on those findings, Petitioner's cognitive test results and her psychological test results were not valid for interpretation because they did not provide a reliable or valid estimate of her status. Resp.'s Ex. 2, p. 25. The doctor testified Petitioner's scores on the cognitive tests were "essentially meaningless" and the psychological tests were of "questionable validity" such that "there might be pieces of those that are reliable and valid, but you really can't know for sure because again she's over reporting symptoms in that case." Resp.'s Ex. 2, p. 25-26.

Dr. Landre opined Petitioner "satisfied the criteria for probable malingering." Resp.'s Ex. 2, p. 31-32. The doctor provided the basis of her opinion:

> The basis for that opinion is her test results including her failure of both performance and symptom validity measures. Her improbably poor findings on the standards [*sic*] neuropsychological indices and inconsistencies between herself [*sic*] reported the symptoms and what we know about the natural course of recovery from concussion as well as other inconsistencies between her self report and information available from other sources. Resp.'s Ex. 2, p. 32.

Dr. Landre further opined Petitioner's test results suggested probable symptom magnification. Resp.'s Ex. 2, p. 33. Asked what Petitioner's neuropsychological level of functioning was as of August 19, 2013, Dr. Landre responded as follows:

> Because of insufficient effort and probable symptom exaggeration, I was unable to provide a valid estimate of her true cognitive or emotional status. But based upon

> the fact that she was driving without restrictions and attending college and obtaining passing grades following both of these injuries, my best estimate was that her true functional status was within normal limits. Resp.'s Ex. 2, p. 33.

Dr. Landre did not believe Petitioner required additional treatment, stating Petitioner had already received more treatment than would be anticipated and she had failed to respond as expected; the doctor further noted Petitioner's test results indicated her complaints were driven by factors unrelated to her injury, such as secondary gain, work avoidance, or financial compensation. Resp.'s Ex. 2, p. 34.

Turning to causal connection, Dr. Landre opined Petitioner's complaints as of August 19, 2013 were not causally related to the two work injuries. Resp.'s Ex. 2, p. 35. The doctor explained her opinion was based on published literature on the natural course of recovery from concussion as well as her test results, experience, and training. Resp.'s Ex. 2, p. 35. Dr. Landre further opined Petitioner was able to return to work full duty without restrictions and should have been symptom-free three months post-injury. Resp.'s Ex. 2, p. 35-36.

On cross-examination, Dr. Landre testified it was "not entirely clear" that Petitioner sustained a head injury. Resp.'s Ex. 2, p. 36. Dr. Landre testified there could have been a head injury the first time, specifically noting, "I had information that there were witnesses," but Dr. Landre stated the mechanism of injury of the second incident, *i.e.*, being pushed from behind, does not necessarily satisfy criteria for concussion. Resp.'s Ex. 2, p. 36. Dr. Landre conceded the March 19, 2013 Central DuPage Hospital records reflect that when Petitioner was evaluated in the emergency room on the date of accident, she reported being punched in the back of the head, but according to Dr. Landre, "she didn't report that initially so it almost seemed like the injury - - her characterization of the injury changed over time." Resp.'s Ex. 2, p. 37.

Dr. Landre testified the American Congress of Rehab Medicine defines concussion as involving either direct injury to the head or an acceleration/deceleration injury as well as some sort of alteration of consciousness at the moment of impact: "They don't have to lose consciousness, frankly. But they have to be dazed or confused or feel out of it temporarily and/or demonstrate some sort of a focal neurologic deficit." Resp.'s Ex. 2, p. 38. Dr. Landre agreed the severity of a blow to the head can be indicated by other physical damage caused by the blow, such as a ruptured eardrum. Resp.'s Ex. 2, p. 38-39. Dr. Landre testified she thought it was likely that Petitioner probably had a concussion with the first incident, but she could not say with 100 percent certainty. Resp.'s Ex. 2, p. 39.

Dr. Landre agreed she asked Petitioner to describe her current complaints prior to giving her the checklist for post-concussive syndrome symptoms, and Petitioner reported nervousness, dizziness, memory difficulties, headaches, stomach aches, sensitivity to the sun and noise, disturbed sleep, vision problems, and depression. Resp.'s Ex. 2, p. 44-46. Dr. Landre confirmed that anxiety, depression, difficulty concentrating, irritability, and fatigue are symptoms associated with both PTSD and post-concussion syndrome. Resp.'s Ex. 2, p. 49-50.

Dr. Landre confirmed her opinion was that work avoidance was a factor in Petitioner's presentation. Resp.'s Ex. 2, p. 61. The doctor then agreed Petitioner returned to work the day after

the first incident and worked for some time thereafter. Resp.'s Ex. 2, p. 61. The doctor was unaware if the employer offered Petitioner a job after the second incident. Resp.'s Ex. 2, p. 61.

The April 10, 2017 evidence deposition of Dr. Alexander Obolsky was admitted as Respondent's Exhibit 4. Dr. Obolsky is board certified in general, addiction, and forensic psychiatry. Resp.'s Ex. 4, p. 5.

At Respondent's request, Dr. Obolsky conducted a forensic psychiatric evaluation of Petitioner. Resp.'s Ex. 4, p. 7. Dr. Obolsky explained his process:

> The forensic psychiatric evaluation sits on three major activities that the focus of each is to generate reliable clinical data. One of these activities is a review of the available records. The other activity is the forensic psychological or neuropsychological testing, and the third activity is the forensic psychiatric interview. Resp.'s Ex. 4, p. 8.

Dr. Obolsky testified psychological testing was conducted on Petitioner on April 29, 2014 and he interviewed her on May 16, 2014. Resp.'s Ex. 4, p. 14. The doctor issued his report on December 31, 2014. Resp.'s Ex. 4, p. 11. Dr. Obolsky testified consistent with his report.

Dr. Obolsky emphasized the behaviors he observed which were inconsistent with PTSD, major depression, and cognitive deficiency. The doctor noted Petitioner did not exhibit any bizarre or odd behaviors which would impair her ability to work with other people. Resp.'s Ex. 4, p. 18. The doctor further noted Petitioner provided a detailed description of the school and classroom where the injuries occurred without exhibiting any emotional distress. Resp.'s Ex. 4, p. 20. Dr. Obolsky testified that Petitioner reported experiencing emotional distress, but the doctor felt Petitioner "misattributes" it to the work injuries as opposed to her pre-existing performance anxiety. Resp.'s Ex. 4, p. 21. Dr. Obolsky testified the inconsistencies indicated that Petitioner was malingering. Resp.'s Ex. 4, p. 23. Dr. Obolsky acknowledged that the diagnostic criteria for PTSD have changed so that they no longer include fear for life, but nonetheless felt that was an important factor when considering the severity of the event to a particular individual. Resp.'s Ex. 4, p. 25.

Dr. Obolsky testified the neurocognitive testing by Dr. Devereux and Dr. Lambert [*sic*] showed that Petitioner malingered, exaggerated her cognitive complaints, and her report of complaints was untrustworthy. Resp.'s Ex. 4, p. 41. Dr. Obolsky stated Petitioner's performance on RBANS, a cognitive test of memory, concentration, attention, and executive functioning, was in the lowest .01 percentile, matching people who have severe end-stage dementia; Dr. Obolsky opined the only explanation is that Petitioner was malingering. Resp.'s Ex. 4, p. 48-49. While Dr. Devereux concluded Petitioner exhibited post-traumatic stress disorder, Dr. Obolsky stated Petitioner's test results are "incontrovertible evidence that Miss Wellman started to malinger and exaggerate her symptoms very soon after the injury." Resp.'s Ex. 4, p. 50-51.

Dr. Obolsky diagnosed Petitioner as exhibiting malingering as well as exhibiting avoidant, dependent, and compulsive personality features. Resp.'s Ex. 4, p. 67. Dr. Obolsky testified the diagnosis of PTSD was inappropriate based on the totality of the data available. Resp.'s Ex. 4, p. 69. The doctor opined Petitioner "is untrustworthy reporter of her symptoms, and she misattributes

the causation that I already testified. She misreports symptoms. She manipulates symptoms. Sometimes she feigns symptoms. And so her credibility as a historian of her own symptoms is undermined significantly because she is clearly malingering." Resp.'s Ex. 4, p. 71.

Dr. Obolsky concluded that Petitioner did not develop any condition of mental ill-being causally related to either the October 23, 2012, or March 19, 2013 work events. Resp.'s Ex. 4, p. 76. The basis of his opinion was his review of the available records, review of the psychological testing by Dr. Devereux, Dr. Landon [*sic*], and Dr. Felske, and his forensic interview with Petitioner. Resp.'s Ex. 4, p. 77. Dr. Obolsky further opined Petitioner did not require any further mental health treatment as a result of either work incident, and she was fit for full-time competitive employment and had no limitations or restrictions causally related to either work event. Resp.'s Ex. 4, p. 77-78.

On cross-examination, Dr. Obolsky confirmed he reviewed the report of Dr. Karen Levine, the neurologist who evaluated Petitioner at Respondent's request on March 7, 2013. Resp.'s Ex. 4, p. 91. As to Dr. Levine's diagnosis of mild post-concussion syndrome, Dr. Obolsky stated, "Inconsistent with the available data, Dr. Levine made that error and that diagnosis." Resp.'s Ex. 4, p. 92. Dr. Obolsky confirmed he noted in his report that Dr. Levine did not appreciate the significance of Petitioner not knowing what "country" she was in; the follow exchange occurred:

Q. Doctor, I'm actually going to refer you to Page 3 of Dr. Levine's report right after it says Neurological Examination. Didn't she say she didn't know that county she was in?
A. My error. It says county.

Q. So that would be a little less bizarre, right, that a person wouldn't know what county they were in, right, than not knowing what country they were in, right?
A. I don't think so. I think that not knowing what county you are in in Chicagoland area would be quite bizarre.

Q. Doctor, what county are you in when you're in Bensenville, Illinois?
A. I don't know where Bensenville is. Resp.'s Ex. 4, p. 92-93.

Dr. Obolsky believes Petitioner exhibited a lifelong set of personality features which interfere with her interpersonal functioning and have led to dysthymia, anxiety, worries, fears, and somatic complaints. Resp.'s Ex. 4, p. 94-95. The doctor confirmed people with somatic complaints are not lying and do experience them. Resp.'s Ex. 4, p. 96. Dr. Obolsky agreed personality features can sometimes become pathological such that the person cannot work or engage in interpersonal relationships. Resp.'s Ex. 4, p. 100-101. Dr. Obolsky testified Petitioner's personality issues are not of the severity to interfere with her going back to work at her previous occupation or any other occupation. Resp.'s Ex. 4, p. 102. Dr. Obolsky highlighted that the Marianjoy physicians diagnosed post-concussive syndrome without knowing whether Petitioner lost consciousness, and "[y]ou cannot do that." Resp.'s Ex. 4, p. 127.

III. CONCLUSION OF LAW

A. Corrections

At the outset, the Commission makes the following corrections to the Decisions of the Arbitrator ("Decisions" or "Decision"):

Corrections to the Decision in Case No. 13 WC 13675

1. The Commission corrects the accident date in the heading on page 18 of the Decision from "November 23, 2012" to "October 23, 2012" consistent with the parties' stipulations

2. The Commission corrects Petitioner's age on page 23 of the Decision from 35 years old on the date of accident to 34 years old on the date of accident consistent with the parties' stipulations.

Corrections to the Decision in Case. No. 13 WC 13676

1. The Commission corrects the date of accident under the Findings section on page 2 of the "ICArbDec" decision form, from "3/19/19" to "3/19/13" consistent with the parties' stipulations.

2. The Commission corrects the Petitioner's marital status under the Findings section on page 2 of the "ICArbDec" decision form, from "single" to "married" consistent with the parties' stipulations.

3. The Commission corrects the accrual date under the Order section on page 2 of the "ICArbDec" decision form, from "March 19, 2013 through July 15, 2015" to "March 19, 2013 through July 15, 2019."

4. The Commission corrects the date of accident in the last paragraph on page 18 of the Decision from "October 23, 2013" to "October 23, 2012."

B. Credibility

The Arbitrator found Petitioner's testimony was not credible. The Commission views Petitioner's credibility differently and finds that the reasons relied on by the Arbitrator are refuted and contextualized by the evidence.

The Commission exercises original jurisdiction and is not bound by an arbitrator's findings. *See R & D Thiel v. Illinois Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 866, 923 N.E.2d 870, 877 (1st Dist. 2010) (finding that when evaluating whether the Commission's credibility findings which are contrary to those of the arbitrator are against the manifest weight of the evidence, "resolution of the question can only rest upon the reasons given by the Commission for the variance.")

The Commission makes the following findings as to Petitioner's credibility:

1. The Arbitrator found that "Petitioner was not diagnosed with a concussion, post-concussion syndrome nor did she report any concussion related symptoms to Dr. Patel, Dr. Celmer or Dr. Hsu," and that Petitioner did not report any headache symptoms or concussion symptoms until she saw Dr. Marzo on February 13, 2013.

The Commission acknowledges that Petitioner was not diagnosed with a concussion or post-concussion syndrome by Dr. Patel, Dr. Celmer or Dr. Hsu and that she did not report any headaches to these three doctors (following the October 23, 2012 accident). However, the Commission notes that Petitioner's reports of ear pain and decreased hearing on the right side to Dr. Patel on October 23, 2012 were consistent with her testimony and history of being punched in the head by a student. Further, the Commission notes that Dr. Patel referred Petitioner to Dr. Celmer, who is an ENT physician, specifically for the diagnosis of traumatic right ear tympanic membrane perforation. The Commission also notes that Dr. Celmer referred Petitioner to Dr. Hsu, who is an ENT surgeon, specifically to discuss undergoing a tympanoplasty to the right ear. With this contextual backdrop, the Commission finds that an analysis of the totality of the evidence indicates Petitioner did indeed sustain concussions after each accident and developed post-concussion syndrome.

The Commission does not agree that Petitioner did not report any concussion related symptoms or that she did not report any concussion symptoms until she saw Dr. Marzo on February 13, 2013 as the record shows several physicians diagnosed Petitioner with concussions and post-concussion syndrome. On February 11, 2013, Dr. Sam Marzo evaluated Petitioner who reported being hit in the head with a fist multiple times during an incident at work in October 2012 and reported that she had been diagnosed with post-concussion syndrome by a neurologist. Dr. Marzo diagnosed Petitioner, *inter alia*, with post-concussion syndrome for which he recommended neurologic management. The Commission notes that it would be speculative to state that Dr. Marzo diagnosed Petitioner with post-concussion syndrome based only on her report that another physician had diagnosed her with the same, when there is no evidence or deposition testimony to support this assertion.

Similarly, on March 7, 2013, Dr. Karen Levine, who performed a section 12 neurological examination of Petitioner at Respondent's request, diagnosed Petitioner with migraines and mild post-concussion syndrome. Dr. Levine opined that Petitioner's migraines were pre-existing and were aggravated by the work injury. Furthermore, even Dr. Landre, who performed an additional section 12 neurological evaluation of Petitioner at Respondent's request, acknowledged "it's likely that [Petitioner] probably had a concussion with this first [accident]," although she could not say with 100 percent certainty. Dr. Landre explained that the American Congress of Rehab Medicine defines concussion as involving either direct injury to the head or an acceleration/deceleration injury as well as some sort of alteration of consciousness at the moment of impact: "They don't have to lose consciousness, frankly. But they have to be dazed or confused or feel out of it temporarily and/or demonstrate some sort of a focal neurologic deficit." Resp.'s Ex. 2, p. 38. Dr. Landre agreed the severity of a blow to the head can be indicated by other physical damage caused by the blow, such as a ruptured eardrum. Resp.'s Ex. 2, p. 38-39.

2. The Arbitrator found Petitioner's testimony that she hit her head on a wall and blacked out on October 23, 2012 is not consistent with the Employee's Report of Injury.

The Commission acknowledges that the Employee's Report of Injury from October 23, 2012 does not state Petitioner hit her head on a wall and blacked out. However, the Commission notes the Employee's Report of Injury states Petitioner was punched in the forehead, nose, and right temporal area/ear by a student while she was trying to calm the student. On the form, Petitioner indicated that she had pain in her right cheek, ear, right eye, and neck. The Commission finds that based on the information which is contained in the Employee's Report of Injury and the totality of the evidence, whether Petitioner hit her head against a wall and blacked out is inconsequential and does not negate the fact that Petitioner sustained a serious head injury on October 23, 2012. Petitioner credibly testified that she was punched in the face, nose, and right ear which is well documented on the Employee's Report of Injury and in various medical records. These injuries, regardless of whether she also hit her head on a wall and blacked out, were traumatic and serious – so serious that her injuries caused a traumatic right ear tympanic membrane perforation and she was later diagnosed with a concussion or post-concussion syndrome by several physicians.

3. The Arbitrator found Petitioner did not provide complete medical histories to various doctors regarding her preexisting symptoms.

The Commission finds that based on the evidence, most of the physicians who examined Petitioner had some knowledge of Petitioner's medical history and pre-existing conditions, however, because the medical records are not sufficiently detailed, it is unclear exactly how much information each physician had regarding Petitioner's medical history. The Commission first notes that Dr. Patel is Petitioner's family physician who treated Petitioner for migraines and associated facial numbness and tingling prior to the October 23, 2012 accident. Petitioner returned to Dr. Patel, who already knew of Petitioner's medical history, after the October 23, 2012 accident. Further, on March 7, 2013, Dr. Levine opined that Petitioner's work injury could have aggravated Petitioner's pre-existing migraines, indicating that Dr. Levine had some knowledge of Petitioner's pre-existing condition.

After the undisputed March 19, 2013 accident, Petitioner treated with Dr. Mehta who practiced with Marianjoy Medical Group. On April 11, 2013, Dr. Mehta acknowledged that Petitioner had a pre-existing history of mild depression and opined that it was likely exacerbated by multiple assaults/concussions. Dr. Mehta referred Petitioner to Dr. Jordania, a neuropsychiatrist who also practiced with Marianjoy to address Petitioner's depression and anxiety. On November 4, 2013, Dr. Mehta transferred Petitioner's care to Dr. Sayyad who also practiced with Marianjoy. The Commission finds the evidence demonstrates Dr. Patel, Dr. Mehta, and Dr. Levine had knowledge of Petitioner's pre-existing medical history. Further, Drs. Jordania and Sayyad both practiced at Marianjoy with Dr. Mehta and most likely had access to Petitioner's records which document pre-existing conditions. In fact, Dr. Sayyad testified that she reviewed Dr. Mehta's treatment notes when she took over Petitioner's care. The Commission finds there is no evidence indicating that Petitioner purposely withheld information about her previous medical history or pre-existing conditions.

Based on the above, the Commission finds Petitioner's testimony was credible and supports her claim of suffering concussions, post-concussion syndrome, migraines, PTSD, anxiety, and depression as a result of both undisputed work accidents where Petitioner was attacked by a student on both occasions.

C. Causal Connection

The Commission finds Petitioner proved by a preponderance of the evidence that the undisputed accidents on October 23, 2012 and March 19, 2013: (1) caused Petitioner to suffer concussions and post-concussion syndrome, which resolved by July 18, 2013; (2) aggravated Petitioner's migraines and resolved by July 18, 2013; (3) caused Petitioner to suffer PTSD, which resolved by September 20, 2016; and (4) aggravated and exacerbated Petitioner's anxiety and depression, which resolved by September 20, 2016.

It is well settled that employers take their employees as they find them; even when an employee has a pre-existing condition which makes him more vulnerable to injury, and recovery for an accidental injury will not be denied as long as it can be shown that the employment was *a* causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205 (2003). An employee need only prove that some act or phase of his employment was a causative factor of the resulting injury, and the mere fact that he might have suffered the same disease, even if not working, is immaterial. *Twice Over Clean, Inc. v. Indus. Comm'n*, 214 Ill.2d 403, 414 (2005).

Moreover, with respect to the applicability of a "chain of events" analysis to a case involving a preexisting condition, courts have found 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." *Schroeder v. Ill. Workers' Comp. Comm'n*, 2017 IL App (4th) 160192WC, ¶¶ 25-26, 79 N.E.3d 833, 839. "The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been." *Id.* The appellate court also noted that "the principle is nothing but a common-sense, factual inference. *Schroeder*, 2017 IL App (4th) ¶ 26; *see also Price v. Industrial Comm'n*, 278 Ill. App. 3d 848, 853-54, 663 N.E.2d 1057, 1060-061 (4th Dist. 1996).

The Commission finds the opinions of Dr. Marzo, Dr. Levine, Dr. Mehta, and Dr. Sayyad to be credible, persuasive, and supported by the record. Additionally, the Commission finds that based on a chain of events analysis, Petitioner proved that the conditions of concussion, post-concussion syndrome, migraines, PTSD, anxiety, and depression were either caused or aggravated by the undisputed accidents.

On February 11, 2013, Dr. Marzo examined Petitioner and diagnosed her with, *inter alia*, post-concussion syndrome and recommended Petitioner continue treating for the condition with a neurologist. On March 7, 2013, Dr. Levine, Respondent's section 12 examining physician, diagnosed Petitioner with mild post-concussion syndrome and opined that Petitioner's pre-existing migraines could have been aggravated by the work injury. After the March 19, 2013 accident, the emergency room physicians at Central DuPage Hospital diagnosed Petitioner with a "new concussion," "post concussive syndrome from a head injury a few months ago," and PTSD from

the first concussion. On April 11, 2013, Dr. Mehta diagnosed Petitioner with post-concussion syndrome, neurobehavioral deficits/neurocognitive, impaired balance, insomnia, anxiety/ depression/PTSD, and chronic post-concussion headaches. Dr. Mehta opined that Petitioner had a pre-existing history of mild depression likely exacerbated by multiple assaults/concussions. On April 22, 2013, Dr. Jordania performed an initial psychiatric evaluation and diagnosed Petitioner with post-concussive syndrome, anxiety due to post-concussive syndrome, PTSD, and insomnia due to PTSD. Petitioner continued to treat with Dr. Jordania and undergo speech therapy, occupational therapy, and day rehab. On June 13, 2013, Petitioner was discharged from speech therapy. Petitioner was discharged from occupational therapy the next day. On July 2, 2013, Dr. Mehta noted Petitioner had completed a day rehab program and transitioned to a home exercise program. Dr. Mehta noted Petitioner was steadily improving but she continued to have significant PTSD symptoms.

On July 18, 2013, Petitioner followed up with Dr. Jordania and reported significant improvement in her headaches, but her PTSD was still very symptomatic. Petitioner described having persistent fear of children and people in public places as well as fear of being attacked. Petitioner continued to treat with Dr. Mehta (until her care was transferred to Dr. Sayyad), Dr. Jordania, and counselor Cromer. On September 20, 2016, Petitioner followed up at Marianjoy with Dr. Sayyad's nurse practitioner, which is the last documented medical visit in the record and reported that she was much less tired during the day and she was doing well in her classes. However, Petitioner reported that her headaches had returned, her blood pressure was slowly climbing, and she was still looking for a psychiatrist to replace Dr. Jordania who had left Marianjoy. Dr. Sayyad's nurse diagnosed Petitioner with, *inter alia,* major depressive disorder, single episode, unspecified and posttraumatic stress disorder; provided Petitioner with names of potential psychiatrists; adjusted Petitioner's medication; and encouraged Petitioner to continue taking classes. Dr. Sayyad testified that Petitioner had started to show some signs of improvement by this date and Petitioner's headaches waxed and waned throughout her treatment. At her deposition, Dr. Sayyad testified that "there is a connection between Ms. Wellman being punched in the head by a student and these diagnoses [post-concussion syndrome, PTSD, neurocognitive deficits associated with PTSD, post-concussion syndrome, and post-traumatic headache]."

The Commission finds that Petitioner was able to work her full job duties prior to the October 23, 2012 accident, and to her credit, even managed to return to work following the October 23, 2012 attack while undergoing treatment for her right ear perforated tympanic membrane. However, after the March 19, 2013 attack, Petitioner was unable to complete her job duties and return to work. The medical records indicate that her concussion, post-concussion syndrome, and migraine conditions improved over time and seemed to resolve or plateau by July 18, 2013. However, the medical records indicate Petitioner's PTSD and associated anxiety and depression did not improve as quickly and Petitioner required substantial treatment and therapy through September 20, 2016.

Furthermore, the Commission is not persuaded by the opinions of Dr. Landre, which were based on inaccurate facts and speculation. Dr. Landre's opinion that it was not clear whether Petitioner sustained a head injury during the second accident (March 19, 2013) is contradicted by the evidence. Dr. Landre testified that Petitioner's March 19, 2013 accident consisted of "being pushed from behind," which did not satisfy the criteria for a concussion. The Commission notes

that the Central DuPage Hospital emergency room records state Petitioner was hit from behind and punched in the occiput by a student. The emergency room physicians diagnosed Petitioner with a "new concussion," post-concussion syndrome and PTSD from the first concussion. Additionally, the Employee's Report of Injury for the March 19, 2013 accident (dated March 20, 2013) states that a student pushed and hit Petitioner in the back of the head. Further, Dr. Landre testified that Petitioner "failed" several performance validity tests in the neurological evaluation and initially opined that it meant Petitioner was likely exaggerating or malingering. However, Dr. Landre later testified that the failed performance validity tests meant the test results were not valid for interpretation and were not a reliable estimate of Petitioner's status. The Commission finds that Dr. Landre's reliance on invalid and unreliable testing to form her opinion that Petitioner was malingering casts doubt on the credibility of her opinion.

Additionally, the Commission is not persuaded by Dr. Obolsky's opinions which were also based on inaccurate facts and speculation. Dr. Obolsky opined that the results of his forensic psychiatric evaluation indicated Petitioner was malingering and exaggerating her complaints. Dr. Obolsky opined that Petitioner did not exhibit any "bizarre" or "odd" behaviors that would impair her ability to work with other people but did not explain what a "bizarre" or "odd" behavior was and did not explain the scientific significance of such behaviors. Additionally, Dr. Obolsky opined that Petitioner did not develop any condition of mental ill-being causally related to either undisputed accident, which contradicts the opinions of the emergency room physicians at Central DuPage Hospital, Dr. Mehta, Dr. Sayyad, Dr. Jordania, and licensed clinical professional counselor Cromer. Finally, Dr. Obolsky inaccurately believed Petitioner had reported not knowing what "country" she was in when Dr. Levine evaluated her, when in actuality, Petitioner had reported not knowing what "county" she was in when she saw Dr. Levine.

Finally, the Commission notes that Dr. Landre and Dr. Obolsky's opinions contradict each other and undermine the credibility of both opinions. On one hand, Dr. Landre testified that in order to be diagnosed with a concussion, loss of consciousness is not required, and Petitioner probably had a concussion after the first accident. Dr. Landre also confirmed that anxiety, depression, difficulty concentrating, irritability, and fatigue are symptoms associated with both PTSD and post-concussion syndrome. On the other hand, Dr. Obolsky testified that the doctors at Marianjoy diagnosed Petitioner with post-concussion syndrome without knowing whether Petitioner lost consciousness and ""[y]ou cannot do that." Dr. Obolsky appeared to opine that loss of consciousness is required for a diagnosis of concussion or post-concussion syndrome.

D. Medical Benefits

Based on the Commission's findings and conclusions above, and with respect to both cases 13 WC 13675 (October 23, 2012 accident) and 13 WC 13676 (March 19, 2013 accident) the Commission finds Petitioner's treatment for concussion, post-concussion syndrome, and migraines was reasonable and necessary, and awards medical expenses for treatment for those conditions through July 18, 2013 pursuant to sections 8(a) and 8.2 of the Act. The Commission finds that with respect to both cases 13 WC 13675 (October 23, 2012 accident) and 13 WC 13676 (March 19, 2013 accident) Petitioner's treatment for PTSD, anxiety, and depression was reasonable and necessary, and awards medical expenses for treatment for those conditions through September 20, 2016 pursuant to sections 8(a) and 8.2 of the Act.

E. Temporary Total Disability Benefits

Based on the Commission's findings and conclusions above, and with respect to case no. 13 WC 13676 (March 19, 2013 accident) the Commission finds Petitioner is entitled to temporary total disability ("TTD") benefits from March 20, 2013 through September 20, 2016. Respondent is entitled to credit for TTD benefits already paid.

F. Permanent Disability Benefits

Our conclusion that Petitioner's concussion, post-concussion syndrome, migraine, PTSD, anxiety, and depression conditions are causally related to the undisputed work accidents, necessarily implicates an analysis of Petitioner's permanent disability with respect to these conditions. The Commission finds the injuries Petitioner sustained following each undisputed accident are not separate and distinct, but rather, Petitioner was attacked and sustained injuries to her head during both accidents and her diagnoses and treatment for the injuries sustained during both accidents overlapped considerably. Further, the Commission finds that the injuries Petitioner sustained during the second accident were amplified and more serious due to the prior injuries Petitioner sustained during the first accident and the evidence does not support delineation of the nature and extent of permanency attributable to each accident. Accordingly, the Commission finds that it can only award permanency for the second accident, case no. 13 WC 13676 (March 19, 2013 accident). *See City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 265, 947 N.E.2d 863, 869 (2011).

The Commission analyzes the §8.1b factors as follows and modifies the Arbitrator's permanency award with respect to case no. 13 WC 13676:

Section 8.1b(b)(i) – impairment rating

Neither party submitted an impairment rating. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner worked as a Health Assistant for Respondent for approximately six years. Petitioner has not returned to her employment with Respondent or any other employer since the March 19, 2013 accident. The Commission gives this factor moderate weight and finds this factor is indicative of increased permanent disability.

Section 8.1b(b)(iii) – age at the time of the injury

Petitioner was 34 years old on the date of the October 23, 2012 undisputed accident. Petitioner was 35 years old on the date of the March 19, 2013 undisputed accident. Petitioner was relatively young at the time of the accidents and has many years to attempt to adapt to her residual deficits. The Commission gives this factor moderate weight and finds this factor is indicative of increased permanent disability.

Section 8.1b(b)(iv) – future earning capacity

Petitioner did not return to her pre-accident job with Respondent and Petitioner's physicians continue to place her off work. Petitioner earned an Associate's Degree in 2019 and is taking additional classes to help her find suitable employment. Petitioner submitted into evidence a vocational assessment report dated November 11, 2013 indicating she had a vocational history of EMT certification, certified phlebotomist, CNA, certification to perform school vision and hearing screenings, licensed cosmetologist, and she had paramedic training. However, Petitioner also had vocational barriers of post-traumatic stress disorder, ruptured eardrum, hand tremors, migraine headaches, jaw problems, eye problems, depression, and anxiety. Respondent submitted into evidence a labor market survey report dated February 29, 2016, which indicated appropriate vocational goals for Petitioner included claims clerk, receptionist, collections clerk, hospital-admitting clerk, radio dispatcher, administrative clerk, customer service clerk, home attendant, and teacher's aide. The wage range for those positions within a 50-mile radius was $12.00 to $23.00 per hour. The Commission gives this factor moderate weight and finds this factor is indicative of decreased permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner testified she returned to school at the College of DuPage in 2017 and completed an Associate's Degree in Applied Science in Human Services for Addictions Counseling in May 2019. Petitioner described her time in college as difficult and she required substantial help and accommodations while she was in school. The medical records corroborate Petitioner's testimony in that they indicate Petitioner failed several classes in 2014 before she was finally able to pass her classes at the College of DuPage. Petitioner testified she has problems sleeping and has nightmares about "these issues occasionally." She gets dizzy and can lose her balance if she stands too quickly from a seated position. She experiences loud ringing in her ears when she gets anxious, which causes her to get "light-headed." Petitioner gets nervous around a lot of people "in newer situations" and she becomes anxious in public. Petitioner continues to take multiple prescription medications.

On September 20, 2016, Petitioner followed up at Marianjoy with Dr. Sayyad's nurse practitioner and reported that she was much less tired during the day and she was doing well in her classes. However, Petitioner reported that her headaches had returned, and her blood pressure was slowly climbing. Dr. Sayyad's nurse diagnosed Petitioner with major depressive disorder, single episode, unspecified; posttraumatic stress disorder, *inter alia*; adjusted Petitioner's medication; and encouraged Petitioner to continue taking classes. Dr. Sayyad testified that at the time of this visit, Petitioner had started to show some signs of improvement by this date and Petitioner's headaches waxed and waned throughout her treatment. The Commission gives this factor significant weight and finds this factor is indicative of increased permanent disability.

Based on the above, the Commission finds Petitioner sustained 17.5% loss of the person-as-a whole. All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 3, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to both case nos. 13 WC 13675 and 13 WC 13676, Respondent shall pay to Petitioner medical expenses as provided in §8(a), subject to §8.2 of the Act, for treatment for Petitioner's concussion, post-concussion syndrome, and migraines through July 18, 2013.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to both case nos. 13 WC 13675 and 13 WC 13676, Respondent shall pay to Petitioner medical expenses as provided in §8(a), subject to §8.2 of the Act, for treatment for Petitioner's PTSD, anxiety, and depression through September 20, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to case no. 13 WC 13676, Respondent shall pay to Petitioner the sum of $337.46 per week for a period of 183 weeks, representing March 20, 2013 through September 20, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to case no. 13 WC 13675, Respondent shall pay to Petitioner the sum of $319.00 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the perforated right eardrum and neck injuries sustained caused 10% loss of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to case no. 13 WC 13676, Respondent shall pay to Petitioner the sum of $319.00 per week for a period of 87.5 weeks, as provided in §8(d)2 of the Act, for the reason that the concussion, post-concussion syndrome, migraine, PTSD, anxiety, and depression conditions sustained caused 17.5% loss of the person-as-a-whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. Respondent shall be given a credit for TTD benefits paid in the amount of $6,122.63 and credit for an advance in permanent disability benefits in the amount of $8,385.14. Respondent shall also 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.

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.

August 9, 2021

/s/ *Deborah J. Baker*

/s/ *Stephen Mathis*

/s/ *Deborah L. Simpson*

DJB/mck

O: 6/9/21

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ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0402
NOTICE OF ARBITRATOR DECISION

WELLMAN, JACKLYN
Employee/Petitioner

Case# **13WC013675**
13WC013676

CASE: GLENWOOD ACADEMY
Employer/Respondent

On 10/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.79% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
PETER J STAVEOPOULOS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JACLYN WELLMAN
Employee/Petitioner

v.

CASE: GLENWOOD ACADEMY
Employer/Respondent

Case # 13 WC 013675 consolidated with
13 WC 13676

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

FINDINGS

On **10/23/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**26,321.88**; the average weekly wage was $**506.19**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**0.00** 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 permanent partial disability benefits of $319.00 /week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act, as set forth in the Conclusions of Law attached hereto.

Respondent shall pay to Petitioner compensation that has accrued from October 23, 2012 through July 15, 2019 and shall pay the remainder of the award, if any, in weekly payments, as set forth in the Conclusions of Law attached hereto.

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

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

Signature of Arbitrator

10/1/2019
Date

OCT 3 - 2019

Procedural History

This matter was tried on July 15, 2019. The disputed issues involve: whether the Petitioner's current condition of ill-being is causally connected to the accidental injuries sustained on October 23, 2012; whether Respondent is liable for medical bills; and the nature and extend of Petitioner's injuries. The parties stipulated that Respondent paid certain medical bills totaling $14,507.77. (Arb. Ex. #1, 2)

Findings of Fact

The parties stipulate that on October 23, 2012, an employer/employee relationship existed between the parties and that Jaclyn Wellman (hereafter referred to as "Petitioner") was employed as a health assistant for CASE Glenwood Academy (hereafter referred to as "Respondent"), which was a school for children with behavior disorders and physical disabilities. (T. 10-13). Petitioner's job entailed dealing directly with the students surrounding their health issues. (T. 13).

It is also stipulated that, on October 23, 2012, Petitioner sustained compensable accidental injuries when she was punched by a seven-year-old student. (T 13-14). Petitioner testified that the student, who was in first grade, weighed between 50 and 60 pounds. (T 15-16).

Prior Medical Treatment

On April 16, 2012, Petitioner treated with Dr. Sapan Patel, of DuPage Medical Group, for migraines. At that visit, Petitioner reported her migraines were getting worse and were occurring more frequently, for longer durations and were becoming more severe. Petitioner reported additional symptoms of blurry vision, fatigue, sensory changes, facial numbness and tingling. Petitioner also reported other symptoms including difficulty talking. Dr. Patel proscribed Topamaz and advised Petitioner to taper off Fioricet which, he said, could be contributing to her symptoms. Dr. Patel ordered an MRI and CT of the brain which he compared to a prior MRI and CT of the brain taken on May 27, 2008. Dr. Patel indicated the scans were normal. Petitioner was diagnosed with chronic migraines. (PX 12)

On August 23, 2010, Petitioner reported to Dr. Patel, symptoms of blurry vision in the left eye, headaches, numbness on the left side of her face and tingling involving the left side of her face, eye, tongue, neck and down her arm. Petitioner also reported being

very fatigued and that she gets tired with even minimal activity. Those records show that Petitioner was taking Xanax, Lexapro and Petitioner had a family history of migraines. (PX 12)

Petitioner's past medical history also included left ear tympanoplasty, depression, anxiety, sleep disorder, psychotropic medications dating back to 2009, celiac disease and being allergic to glutens which causes nausea and vomiting. (RX 1 and PX 5).

Petitioner testimony regarding her health prior to the incidents.

Petitioner testified that prior to October 23, 2012, she could exercise on a regular basis, could run, did not take medication for any reason, and could see properly. (T. 29).

Petitioner's testimony regarding her work Accidents

Petitioner testified that the first incident occurred on October 23, 2012, when a student was brought down to her office after a fight. The student was seven years old, in first grade, and maybe weighed between 50-60 pounds. Petitioner testified that the student punched her in the bridge of her nose, mouth and right ear and jaw. Petitioner also testified that she flew back and hit her head on the wall and that she blacked out. Petitioner testified that when she woke up, another staff member was in the room taking the student away. Petitioner testified that she completed an incident or accident report. (T. 16). Petitioner testified that she continued to work after this incident.

Petitioner testified that, on March 19, 2013, she was struck by another student who was eight years old and weighed between 60-70 pounds. Petitioner testified that she was in a classroom administering medication when a student punched her in in the middle of her back, jumped on her back and started punching her in the neck and back of the head. Petitioner testified that as she tried to move she hit her forehead on the wall in the front of the room and blacked out. (T. 20-22). Petitioner testified that she competed a second accident report. (T. 22).

Accident Reports

On October 23, 2012, Petitioner completed an Employee's Report of Injury. On the form, Petitioner indicted that she was punched in the forehead, nose and right temporal area or ear. Petitioner listed her pain areas as the cheek, ear, neck, and right eye. (PX 1). A co-worker who witnessed the incident, Denise Polick, completed a

statement. Ms. Polick stated that Petitioner was hit in the bridge of her nose, end of her nose, and the area of her right ear. (PX 1).

On November 16, 2012, Petitioner filed a police report with the Glendale Heights Police Department for the October 23, 2012 incident. At that time, Petitioner reported being punched once in the bridge of her nose, twice on the tip of her nose and three times in the temporal area. Petitioner also reported hearing loss and her nose was swollen. (PX 1).[1]

On March 20, 2013, Petitioner completed an Employee's Report of Injury for the March 19, 2013 incident. On that form, Petitioner indicated that she was pushed on her back, was hit her in the back of the head, and her head whipped back. Petitioner reported that her head and neck were injured. Petitioner listed the areas of pain as the head, eyes, ears and neck. (PX 1).

Medical Treatment

On October 23, 2012, Petitioner treated with Dr. Patel, of DuPage Medical Group. At that visit, Petitioner reported being hit in the forehead, nose and ear. Petitioner complained of right ear pain and decreased hearing. The examination of Petitioner's head showed no contusions, ecchymosis, and Petitioner's facial bones were stable. The examination of the right ear showed a central perforation of the tympanic membrane or TM. Dr. Patel diagnosed a right ear perforation and he recommended Petitioner follow up with an ENT. (PX 12).

On October 24, 2012, Petitioner was examined by Dr. Andrew Celmer, of the Glen Ellen Clinic Department of Otolaryngology. At that visit, Petitioner complained of right ear pain and hearing loss. Petitioner reported being struck in the head and nose by a student. Dr. Celmer's records state that Petitioner had no other complaints other than a sore nose. Dr. Celmer assessed a right ear tympanic membrane (TM) tear and he attempted to apply a patch, but Petitioner could not tolerate it. Dr. Celmer recommended dry ear precautions and he believed the TM would likely heal on its own. A follow up appointment was scheduled in six weeks. (PX 3).

[1] The Arbitrator notes that Petitioner's Report of Injury, Police Report and witness statement do not indicate that Petitioner struck her head on a wall and blacked out.

On December 5, 2012, Petitioner returned to Dr. Celmer who noted that Petitioner's symptoms remained unchanged. Dr. Celmer's records state that Petitioner had no other complaints. Dr. Celmer indicated that Petitioner would likely need a tympanoplasty and he referred Petitioner to Dr. Hsu. (PX 3).

On December 14, 2012, Petitioner was seen by Dr. Gregory Doefler, DDS. Petitioner reported being struck by a client, on October 23, 2012, and she felt a pop in her ear and, after a few hours, her jaw stiffened up. Petitioner also reported a popping on her right side. Dr. Doefler ordered a CT scan of the oral and maxillofacial structures which showed no osseous or soft-tissues abnormalities. (PX 11).

On December 18, 2012, Petitioner started treating with Dr. Hsu, of the Glen Ellen Clinic. At that visit, Petitioner reported hearing loss after being struck in the right ear. Dr. Hsu recommended tympanoplasty and allograft reconstruction which was performed on January 7, 2013. The operative findings revealed a 20% perforation. (PX 13)

Petitioner returned to Dr. Hsu on January 22, 2013, February 21, 2013 and March 7, 2013. Dr. Hsu's records state that Petitioner communicated well, was comfortable and under no apparent distress. Petitioner complained of muffled hearing. Audiological diagnostic testing was ordered for the following visit. (PX 13).

On February 13, 2013, Petitioner was examined by Dr. Sam Marzo, of Loyola Medicine, pursuant to Section 12 of the Act, for evaluation of the right ear and head. Petitioner reported being struck multiple times with fists by a student. Petitioner reported to Dr. Marzo that she was told by a neurologist that she had post-concussive syndrome, occipital neuralgia, tinnitus in both ears, and TMJ.[2] Petitioner complained of a stiff jaw.

Dr. Marzo assessed central perforation of tympanic membrane, post-concussion syndrome, conductive hearing loss, subjective tinnitus and otogenic pain. Dr. Marzo indicated that Petitioner's ear pain and tinnitus should improve over time and Petitioner should continue treating with her neurologist for post-concussive syndrome and TMJ. (PX 16).

[2] The Arbitrator notes that Petitioner did not testify that she treated with a neurologist and was diagnosed with post-concussive syndrome, occipital neuralgia, tinnitus or TMJ between October 23, 2012 and March 19, 2013. The Arbitrator also notes that Petitioner did not submit into evidence the records from Dr. Chang or any other neurologist she treated with between October 23, 2012 and March 19, 2013.

After the second incident, on March 19, 2013, Petitioner went to the emergency room at Central DuPage Hospital. At that time, Petitioner reported being pushed by a student, and was punched in the back of the head near the base of her head. Petitioner reported dizziness and nausea. The emergency room records indicated that Petitioner reported treating with a neurologist, at DuPage Medical Group, for post-concussion syndrome from an October head injury.[3] The emergency room records state that Petitioner reported "*at work-shoved by a student, my head went back, then he went to punch me again and he hit me in the back of the skull, I have post-concussion from another student and have constant headaches which is worse now, I feel nauseated and dizzy.*" (PX 15). Petitioner reported suffering a "significant concussion" by Dr. Chang. The emergency room records state that Petitioner did not suffer a loss of consciousness, numbness, tingling or weakness anywhere. A CT scan performed which was negative. The emergency room clinical impression was listed as no diagnosis found. (PX 15).

The emergency room records also state that patient had a new concussion with post-concussive syndrome from a head injury a few months ago, and that she appears to be also be suffering from PTSD from her first concussion. Petitioner was released from the hospital, given a name of a neurologist and told to follow up with her primary care physician. (PX 15).

On April 4, 2013, Petitioner was examined by Dr Sachin Mehta of Marianjoy Medical Group. The medical records state the reason for the visit was post-concussive (10/23/2012) and PTSD (3/19/2013). At that visit, Petitioner reported an initial traumatic event in October 2012 when she was punched by a student between the eyes and on the right side of her scalp. Petitioner reported suffering a ruptured tympanic membrane. Petitioner also reported being diagnosed with post-concussion syndrome and that she was been treating with Dr. Chang a neurologist.[4] Dr. Mehta's records show that Petitioner complained of ongoing headaches, impaired balance, insomnia, mood issues and that she returned to work. Petitioner reported that a second incident that occurred at work on

[3] The records from DuPage Medical Group do not show that Petitioner was treating with a neurologist for post-concussion syndrome after Petitioner's October 23, 2012 accident.

[4] The Arbitrator notes that Petitioner did not testify that she treated with Dr. Cheng, a neurologist, was diagnosed with post-concussion syndrome after the October 23, 2012 accident.

March 19, 2013. Petitioner said she has hit from behind by a student, punched in the occiput. (PX 8)

At this visit, Petitioner complained of trouble with "flipping letters, numbers, directions" calculating difficulties, being more irritable and less tolerant of her kids. Petitioner also reported constant headaches and eye twitching. Petitioner reported feeling nervous, anxious, and feeling fatigued most of the day. Petitioner said that she was advised that she has PTSD. Dr. Mehta noted that Petitioner reported feeling a loss of control over her life because she was working 37 hours a week, attending classes 2-6 hours a week, her husband was not working and was on disability and not helping around the house, and that she was the primary caregiver for her children. Dr. Mehta diagnosed post-concussion syndrome, neurobehavioral deficits/neurocognitive, impaired balance, insomnia, anxiety/depression/PTSD, chronic post-concussion headaches. (PX 8)

On April 15, 2013, Petitioner was seen in the emergency room of Glen Oaks Hospital. The records state that Petitioner was well until 12:30, in the afternoon, when she developed a right-sided headache and numbness on the left side of her tongue and left lips. Petitioner also reported numbness in her left arm and left leg. The records state that Petitioner has a history of migraines with atypical aura of "flashing light" and that she takes Topamax, 75 mg twice daily, and prophylaxis, and butalbital. The emergency room records show that Petitioner reported being punched in the face, in October, and experiencing a brief loss of consciousness. The records also show that Petitioner reported sustaining a second head injury, in March, after being hit from behind. The emergency room records show that Petitioner reported headaches, frequent nausea, postural dizziness and difficulty with balance since October of 2012. CT scans taken of the brain were normal. Petitioner was told that she could increase her Topamax to 100 mg twice daily. Petitioner was diagnosed with migraine syndrome. (PX 14).

On April 22, 2013, Petitioner was seen by Dr. Nina Jordania, MD, of the psychiatry department of Behavioral Health Services at Central DuPage Hospital. At that time, Petitioner reported a history of two consecutive concussions. Dr. Mehta refereed Petitioner to Dr. Jordania for the treatment of Petitioner's anxiety. At that visit, Petitioner reported that since her first concussion she had been experiencing constant headaches, with photo and phonophobia, arm/elbow tingling, can't focus, can't sleep,

nausea, twitching, sadness, fear, unable to drive due to poor balance, irritability, and worrying.[5] Petitioner also reported ringing in her ears like sirens in her head. Dr. Jordania noted that Petitioner past medical history included mild depression, anxiety, celiac disease and that she is allergic to glutens which cause nausea and vomiting. Dr. Jordania diagnosed Petitioner with anxiety due to post-concussion syndrome, PTSD, post-concussion syndrome and insomnia due to PTSD. (PX 5).

On June 6, 2013, returned to Dr. Hsu. At that time the audiogram was taken which showed normal hearing. At that visit, Petitioner reported that she was treating with a neurologist and at Marianjoy. Petitioner complained of headaches, balance problems, and ringing in both ears. Dr. Hsu released Petitioner from care. (PX 13).

On July 18, 2013, Petitioner returned to Dr. Jordinia reporting a significant reduction of headaches after switching to Dexakote from Topamax. (PX 6).

On July 31, 2013, at the recommendation of Dr. Mehta, Petitioner sought counseling services from Steve Cromer, LCPC, at Pathways Psychological Services. Mr. Cromer provided individual counseling to Petitioner until July 1, 2015. Mr. Cromer reported that Petitioner was depressed, overwhelmed, exhausted, sad and angry and he related Petitioner's inability to work was due to fears and symptoms of PTSD. (PX 5).

On August 19, 2013, Petitioner was examined by Dr. Nancy Landre, a licensed clinical psychologist who is board certified in clinical neuropsychology, pursuant to Section 12 of the Act. At that visit, Petitioner reported being stuck by a 7-year-old in the nose and right temporal/ear area on October 23, 2012. Petitioner reported seeing her PCP and ENT (Dr. Celmer) and undergoing an audiological evaluation on March 7, 2013, which showed normal hearing sensitivity and excellent speech discrimination abilities. Petitioner also reported she later developed persistent tinnitus which her treating doctor opined was unrelated to her hear injury. (RX 1).

Petitioner reported that after returning to work she started to experience headaches, jaw pain, fever, and dizziness. Petitioner advised Dr. Landre that she started seeing Dr. Rikert, whom she previously treated with for headaches. Petitioner also advised Dr. Landre that she started to experience eye twitching, nausea, sleep

[5] Dr. Jordania's records do not indicate that Petitioner was treating with Dr. Patel prior to the October 2012 for migraines and that she previously experienced symptoms of headaches, blurry vision, facial numbness and tingling, sensory changes, fatigue, and episodes of being unable to talk.

disturbances and other post-concussive symptoms. Petitioner reported that she was symptomatic but continued to work until March 3, 2013. On that day, Petitioner reported that she was pushed from behind by a second grader. Dr. Landre noted the Employer's Report of Injury, states that Petitioner was pushed from behind causing her to stumble but she did not fall or strike her head on anything. Dr. Landre also noted that Petitioner treated at Central DuPage Hospital and those records showed that Petitioner did not report a loss of consciousness, a CT scan taken that day was normal, and her examination was found to be unremarkable. Petitioner was discharged with no diagnoses being found. (RX 1).

Dr. Landre noted that Petitioner said that she stopped working after the second incident and that she was referred to Dr. Mehta, Marianjoy, by Dr. Cheng and another neurologist, which she sought a consultation.[6] Dr. Landre indicated that Petitioner underwent a neuropsychological evaluation with Dr. Nancy Devereux, on May 1, 2013, who found Petitioner's evaluation to be invalid. Dr. Landre noted that Dr. Devereux determined that Petitioner significantly under-reporting her mental/personal problems while over-reported her somatic and cognitive problems. Dr. Landre noted that Dr. Devereux recommended a treatment plan for PTSD, which Petitioner declined. Dr. Landre also noted that Petitioner's past medical history included migraines, left ear tympanoplasty, significant psychiatric history for treatment of depression, anxiety, sleep disorder with psychotropic medications dating back to 2009. (RX 1).

Dr. Landre noted that Petitioner failed several stand-alone and embedded validity measures. Dr. Landre stated that Petitioner showed significant elevated scores on self-reported measures intended to identify malingering and her scores showed marked symptom over-reporting. Dr. Landre noted that Petitioner's cognitive tests were not valid because they portray her much more impaired than she was. Dr. Landre opined that Petitioner's self-reporting injuries related symptomatology was not credible. Dr. Landre also found Petitioner's performance on standard cognitive results were improbably low, at a level typically seen in patients with severe brain injuries or advanced dementia. (RX 1).

[6] Petitioner did not submit into evidence the records of Dr. Cheng or the other neurologist which she sought a consultation.

Dr. Landre opined that Petitioner's cognitive tests results and responses to self-reporting measures reflect probable symptom magnification. Dr. Landre further opined that Petitioner does not need further treatment and that any complaints she has would be driven by factors unrelated to her injuries. Dr. Landre opined that Petitioner's complaints were not causally related to her work injuries but were being maintained by other factors such as work avoidance or possible financial renumeration. Dr. Landre also opined that Petitioner could return to work full duty without restrictions. (RX 1).

On August 27, 2014, Petitioner returned to Dr. Jordaia who indicated that Petitioner scored 30/30 on a MMSE. Dr. Jordania's records state that the test was not useful, in Petitioner's case, to detect cognitive defect. Petitioner continued to treat with Dr. Jordania until May 11, 2016. (PX 6).

Petitioner returned to Marianjoy on September 20, 2016 and was seen by Dr. Sayyad's nurse practitioner, Sylvia Duraski. Petitioner reported a return of headaches. The medical records state that Petitioner was alert, oriented, appeared to be smiling more and was more optimistic. Petitioner was given the names of potential psychiatrists to follow up since Dr. Jordania left the area. Petitioner was encouraged to continue taking classes she enjoys so she will be more successful. Petitioner was advised to return in six months or sooner should a problem arise. Petitioner did not return for additional treatment. (PX 4).

On December 31, 2014, Dr. Obolsky performed a Forensic Psychiatric Examination, pursuant to Section 12 of the Act. The forensic psychiatric evaluation was performed to assess Petitioner's reported mental health as a consequence of the Petitioner's work accidents. The forensic psychiatric evaluation consisted of over 36 hours of record review, forensic psychiatric interview, forensic psychological and cognitive testing and data analysis. (RX 3).

Dr Obolsky opined that Petitioner's complaints of subjective trauma-related mental, emotional, and cognitive symptoms were not reliable. In his report, Dr. Obolsky stated that the objective evidence does not support Petitioner's reported subjective complaints. Dr. Obolsky opined that Petitioner was malingering (i.e. symptom exaggeration for secondary gain) and that she suffers from avoidant dependent and compulsive personality features not causally related to her work accidents. (RX 3).

In his report, Dr. Obolsky opined there was no objective evidence that Petitioner's work accidents caused any clinically significant mental, emotional or cognitive dysfunctions. Dr. Obolsky noted that Petitioner endorsed over 40 current assorted symptoms involving various bodily systems on medical psychiatric questionnaires. Dr. Obolsky stated that, on the forensic psychological testing, Petitioner exaggerated somatic and cognitive complaints consistent with malingered neurocognitive dysfunction and she also inconsistently magnified her psychiatric symptoms.

Dr. Obolsky stated that that Petitioner's reported posttraumatic symptoms during the forensic psychiatric interview but her description of some of the pathognomonic posttraumatic stress disorder symptoms were phenomenologically inauthentic. Dr. Obolsky noted that Petitioner's performance on forensic psychological testing was erratic. Dr. Obolsky stated that Petitioner made deliberate and unsophisticated attempts to represent herself in an unrealistically virtuous way on the MMPI-2 test. (RX 3).

Dr. Obolsky determined that Petitioner made non-credible over report of psychiatric, cognitive and physical symptoms. In the report, Dr. Obolsky noted that five months after Petitioner's second work injury, Dr. Landre noted that Petitioner failed symptoms validity testing and she displayed abnormal performance on multiple neurocognitive tests. Dr. Obolsky further noted that Dr. Landre assessed malingering after Petitioner's neurocognitive and psychological tests results were found invalid because of multiple failed symptoms validity indicators and evidence of over reporting on self-reporting measures. (RX 3).

Dr. Obolsky opined that the results of two neuropsychological evaluations don't offer objective evidence of mental, emotional or cognitive symptoms of post-concussion syndrome. Dr. Obolsky further opined that Petitioner did not develop post-traumatic stress disorder due to her work accidents and Petitioner could return to work full duty. (RX 3).

Surveillance

Beginning April 24, 2013 and ending through May 7, 2017, on six separate dates, Respondent conducted surveillance of Petitioner. During the surveillance, Petitioner was observed opening her front door, carrying a garden hose and two rakes, putting items into

a trash container, carrying a bag of trash, shipping at a store and pushing a shopping cart, getting mail and carrying empty bags and sitting and walking in a playground. (RX 6).

Evidence Depositions

Dr. Sayyad/Treating physician

Dr. Sayyad testified by evidence deposition on March 1, 2017. (PX 10). Dr. Sayyad testified that she did not see the Petitioner until January 30, 2014 because she previously treated with her partner, Dr. Mehta. (PX 10).

Dr. Sayyad testified that Petitioner complained of light and sound sensitively, lightheaded, and had problems with attention, memory, concentration, dizziness. Dr. Sayyad testified that Petitioner reported to the nurse that she also had ringing in both ears, vision concerns, blurred vision in the left eye and headaches. Dr. Sayyad testified that Petitioner said her symptoms were the result of post-concussion syndrome and PTSD as a result of being punched in the head in October of 2012. (PX 10).

Dr. Sayyad testified that she last saw Petitioner on September 20, 2016 and, at that time, Petitioner had a much brighter affect, was smiling and appeared more optimistic and her speech was fluent. Dr. Sayyad testified that his partner had diagnosed Petitioner with post-concussion syndrome, PTSD, neurocognitive deficits associated with PTSD, post-concussion syndrome and post-traumatic headaches. Dr. Sayyad opined there was a connection between the Petitioner being punched in the head and her diagnoses. Dr. Sayyad testified that her opinion was based upon her medical judgment and that you need a pretty significant trauma to the head to have a diagnoses of post-concussion syndrome and the associated symptoms. (PX 10).

Dr. Sayyad also opined that, as of September 20, 2016, Petitioner was unable to work because her headaches had not completely resolved and because her condition was not stabilized since Petitioner was still looking for a new psychiatrist. (PX 10).

On cross-examination, Dr. Sayyad testified that she had not reviewed any of Petitioner's neuropsychological testing. Dr. Sayyad acknowledged ordering neuropsychological testing, on January 6, 2015, which was not completed in more than two years. (PX 10).

Dr. Sayyad testified that she only reviewed the medical records from Marianjoy and she was not aware that Petitioner suffered form headaches in 2007. Dr. Sayyad

further testified that she could not give an opinion as to Petitioner's current condition because she had not examined Petitioned in over two years. (PX 10).

Dr. Nancy Landre/Section 12 Examiner

Dr. Nancy Landre was deposed on March 9, 2017. Dr. Landre is a clinical psychologist specialty trained in neuropsychology. Dr. Landre testified that she sees patients in the areas of dementia, learning disabilities, ADHD, head injuries and other neurological disorders. Dr. Landre testified that she was the clinical neuropsychologist that consulted with the level one trauma center at Lutheran General Hospital in the traumatic brain injury program. (RX 2)

Dr. Landre testified that Petitioner's past medical history was significant for migraines, which Petitioner attributed to fluorescent lights in her work place, left ear tympanoplasty, depression, anxiety, sleep disorder, and celiac disease. Petitioner's depression and sleep disorders dated back to 2009. (RX 2)

Dr. Landre testified that Petitioner reported being struck by a 7-year-old student and that she did not lose consciousness, but she did feel dizzy and saw stars. Petitioner was diagnosed with a right TM perforation and she had surgery on January 17, 2013. Dr. Landre noted that an audiogram, taken 2 months later, showed normal hearing sensitivity and excellent speech discrimination ability in the ear. Dr. Landre testified that Petitioner reported complaining of tinnitus, but her doctor opined that it was unrelated to her injury and discharged Petitioner from care. (RX 2)

Dr. Landre testified that Petitioner reported a second accident, occurring on March 19, 2013, when she was pushed from behind by a second-grade student. Petitioner reported that she briefly lost her balance, but she did not fall or strike her had on anything. Petitioner was treated at Central DuPage Hospital. Dr. Landre testified that Central DuPage Hospital records showed that Petitioner's examination was unremarkable, and a CT scan was negative. Petitioner reported being referred to Dr. Mehta, at Marianjoy, who diagnosed post-concussion syndrome and recommended the outpatient brain injury day rehab program at Marianjoy. (RX 2)

Dr. Landre testified that, on May 1, 2013, Petitioner saw Dr. Devereux who determined that Petitioner showed insufficient effort and performance during symptom validity testing. Dr. Landre testified that she also conducted neuropsychological testing

and her findings, just as Dr. Devereux findings, also showed problems with Petitioner's effort and credibility regarding self-report of injury related symptoms. Dr. Landre noted that Dr. Devereux recommended a highly effective treatment for PTSD which Petitioner declined. The treatment involved exposure to work. Dr. Landre testified that one of the best available treatments for PTSD is exposure to work. Dr. Landre testified that when asked about returning to work, Petitioner responded that thinking about returning to work made her feel nauseous. (RX 2)

Dr. Landre testified that one of the best measures of symptom validation tests is the MMPI (Minnesota Multiphasic Personality Inventory). Dr. Landre testified that Petitioner failed a number of the symptom validity tests which showed that Petitioner was over-reporting her symptoms. (RX 2)

Dr. Landre testified that Petitioner's cognitive test and psychological tests results were found not to be valid for interpretation because the tests did not provide reliable or valid estimate of what was really going in those domains. Dr. Landre testified that on some of the performance validity tests, Petitioner performed worse than patients with severe dementia in a hospital setting. (RX 2)

Dr. Landre testified that there is a predictable pattern of performance with mild head injuries, and Petitioner's patterns of deficits were not consistent with those predictable patterns. Dr. Landre testified that she would never expect to see someone with severely negative impaired spatial abilities, like Petitioner, or someone with moderately impaired fine motor skills, like Petitioner, in a case involving a mild head injury. Dr. Landre testified that she would not expect to see any effect at all on fine motor skills. (RX 2)

Dr. Landre's opined Petitioner's symptoms are related to malingering. Dr. Landre testified that she based her opinion upon the test results, Petitioner's failure on both performance and symptoms validity measures, Petitioner's poor finding on the standard neuropsychological indices and inconsistencies between self-reported and what we know about the nature and course of recovery from concussions. (RX 2)

Dr. Landre also opined that Petitioner's current condition were related to symptom magnification. Dr. Landre testified that she was unable to provide a valid estimate of Petitioner's true cognitive or emotional status based upon the testing because

of Petitioner's insufficient effort during testing and symptom exaggeration. Dr. Landre opined that Petitioner's true functioning status was within normal limits based upon Petitioner attending college, passing classes, and driving without restrictions. (RX 2)

Dr. Landre opined that based upon the test results, history of reported symptoms Petitioner's complaints is being maintained by secondary gain, work avoidance or financial compensation. (RX 2)

Dr. Obolsky/Section 12 Examiner

Dr. Obolsky's evidence deposition occurred on April 10, 2017. Dr. Obolsky is board certified in general and forensic psychiatry. Dr. Obolsky testified that Petitioner did not report a loss of consciousness, mental status changes or post-traumatic amnesia when she described her work accidents which, he said, was consistent with the emergency room findings. (PX 4).

Dr. Obolsky testified that Petitioner said she reported, after the March incident, that she was experiencing dizziness, nausea, slurred speech, confusion and nonreactive pupils. Dr. Obolsky testified nonreactive pupils are present post-traumatically when you have a very sever traumatic brain injury are signs of virtual death. Dr. Obolsky testified that had a patient presented to the emergency room with nonreactive pupils and slurred speech the emergency room would have taken life saving measures and, if such symptoms existed, it would had been documented in the emergency room records. Dr. Obolsky noted that the emergency room records indicated that Petitioner's speech was not slurred, her pupils were equal in diameter and reactive to light, and she was not confused and was alert and oriented in all spheres. (PX 4).

Dr. Obolsky testified that Petitioner is a medical professional who has some medical education and she may know the term nonreactive pupils, but most lay people do not. Dr. Obolsky testified that the use of these terms reflects a conscious exaggeration of symptom. (PX 4).

Dr. Obolsky also testified that Petitioner reported her jaw was knocked out of place and she had jaw symptoms after the first incident. Dr. Obolsky testified that Petitioner's jaw symptoms did not appear in any medical records until February 6, 2013, three and a half months after the October 2012 event. Dr. Obolsky testified that this

shows that Petitioner is purposefully not giving a clear history of her illness suggesting symptom exaggeration. (PX 4).

Dr. Obolsky testified that, after reviewing the results from the psychological testing, Petitioner is misattributing causation. Dr. Obolsky testified that Petitioner is piling up every symptom she can think of, whether it's present or not, and she claims they are all caused by either the first or second injury. Dr. Obolsky testified that Petitioner is misattributing causation of her physical symptoms to an event for which she could receive compensation which is malingering. (PX 4).

Dr. Obolsky testified that Petitioner reported that she started to experience memory difficulties after the March 2013 incident. Dr. Obolsky noted that the first time Petitioner reported memory difficulties was during the IME, with Dr. Lnadre, on March 7, 2013, one week before the March incident. Dr. Obolsky testified that, at that time, Petitioner reported that she did not know what country or town she was in. Dr. Obolsky testified that one must have a very significant traumatic brain injury not to know that you are in United States or Chicago. (PX 4).

Dr. Obolsky testified that a neurologist, Dr. Cheng, performed an evaluation of Petitioner on February 7, 2013, one week before she was examined by Dr. Levine, and also performed a mental status exam which found Petitioner to be alert, oriented in all spheres and her memory, attention and concentration was normal. Dr. Obolsky testified that, based upon Dr. Cheng's examination, one month before Petitioner's second accident, her mental state was normal. Dr. Obolsky testified that this issue is significant because it shows that Petitioner did not have any cognitive symptoms after her first injury and it also shows that Petitioner started lying before the second accident. (PX 4).

Dr. Obolsky testified that the way traumatic brain injuries work is that something happens, your brain is bruised, and you, immediately, develop symptoms and, over time, the symptoms improve. Dr.Obolsky testified that the symptoms should steadily improve and resolve within 3 months of the event. (RX 4).

Dr. Obolsky further testified that after reviewing all of the physical symptoms reported and Petitioner's complaints listed in the questionnaire Petitioner endorsed over 50 separate physical complaints. Dr. Obolsky opined that both Dr. Devereux and Dr.

Landre's neurocognitive testing shows that Petitioner malingered, exaggerated cognitive complaints and her subjective cognitive complaints are untrustworthy. (RX 4).

Dr. Obolsky testified that Dr. Devereux's neuropsychological testing, performed on May 1, 2013, six weeks after the second work accident, shows that Petitioner was malingering her symptom. Dr. Obolsky testified that on the RBANS test, Petitioner performed in the lowest .01 percentile and her scores were the same as people with severe end-staged dementia. Dr. Obolsky testified that the RBANS test is a cognitive test of memory, concentration, attention, and executive functioning. Dr. Obolsky opined that the MMPI-2 test showed that Petitioner was exaggerating her physical symptoms. (RX 4).

Dr. Obolsky further opined the VSVT showed that Petitioner was a malinger. Dr. Obolsky testified that a person is who is a malinger will perform well on the part of the VSVT they believe is easy and will do poorly on the part of the test they believe is hard. Dr. Obolsky testified that both parts of the test are of equal difficulty. Dr. Obolsky testified that Petitioner performed in a valid range on the perceived easy part of the test and she performed in the questionable range on the perceived hard part of the test. (RX 4).

Dr. Obolsky diagnosed malingering with avoidant dependent and compulsive personality features. Dr. Obolsky testified that his diagnoses were based upon the review of the medical records, performance of psychological testing, review of the psychological neurocognitive tests and his interview with Petitioner. (RX 4).

Dr. Obolsky opined that Petitioner did not suffer any post-traumatic disorder based upon the totality of the data which included the medical records, psychological testing, and neurocognitive testing. Dr. Obolsky testified that symptoms were missing to diagnose PTSD. Dr. Obolsky testified that Petitioner's intrusive symptoms were not authentic, her avoidance symptoms were inconsistent, and her hyperarousal symptoms were not authentic. Dr. Obolsky opined that it is inappropriate to diagnose PTSD, in this case, because Petitioner was an untrustworthy reporter of her symptoms, she misattributes the causation, misreports symptoms and she manipulates symptoms. (PX 4).

Dr. Obolsky further testified that Petitioner's credibility, as a historian of her own symptoms, is undermined significantly because she clearly malingering. Dr. Obolsky testified that it is inappropriate to diagnose PTSD under such conditions. Dr. Obolsky

noted that Petitioner refused PTSD treatment offered by Dr. Devereux and the people who diagnosed PTSD did not treat Petitioner as if she had PTSD. (RX 4).

Dr. Obolsky also opined that Petitioner did not suffer a concussion in either work accident. Dr. Obolsky testified to be diagnose with a concussion you have to exhibit one of the four symptoms immediately after the physical force is applied to the head. Dr. Obolsky testified to be diagnosed with a concussion, you must, immediately, develop a loss of consciousness or mental state changes or post-traumatic amnesia or focal neurological signs. Dr. Obolsky testified that Petitioner did not immediately develop any of the four symptoms for both incidents. (RX 4).

Dr. Obolsky opined that Petitioner did not develop any condition of mental ill-being causally related to either the October 23, 2012 or March 19, 2013 work events. Dr. Obolsky further opined that Petitioner does not require additional medical care and she could return to work full duty, without restrictions. (RX 4).

Petitioner's Education

Petitioner testified that after the March 19, 2013 accident she started to take classes at College of DuPage. In May of 2019, Petitioner received an associate degree in applied science and human services for addiction counseling. Petitioner testified that the degree takes two years to complete. Petitioner testified that she also has an associate degree in in general studies and she is certified as an emergency medical technician, both earned prior to 2012. (T. 34).

Petitioner's Current Complaints

Petitioner testified that she still suffers sleeping problems, dizziness, when she stands up too quickly, and the tinnitus causes ringing in her ears which gets louder when she gets light-headed. Petitioner testified that she gets anxious when the ringing gets louder. Petitioner testified that she gets tingly everywhere. very dizzy and she needs to lay down. Petitioner testified that she gets nervous around a lot of people, in new situations and she needs to know whose around. Petitioner testified that she gets anxious in grocery stores and needs to find landmarks when going to the park, so she could find her car. (T. 36-38).

The Arbitrator does not find the testimony of Petitioner to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223.Ill App. 3d 706 (1992).

In support of the Arbitrator's decision related to issue (F): Is Petitioner's Current Condition of Ill-Being Causally Connected to the Accidental Injuries of November 23, 2012, the Arbitrator makes the following conclusions:

Accidental injuries need not be the sole cause of the Petitioner's current condition of ill-being as long as the accidental injuries are a causative factor resulting in the current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193 (2003).

The Arbitrator finds, after reviewing all of the evidence, that Petitioner has proven by the preponderance of the evidence, that her perforated right eardrum and neck pain was causally related to the October 23, 2012 accident. The Arbitrator further finds that Petitioner failed to prove by the preponderance of the evidence that she sustained a concussion, post-concussion syndrome, PTSD, TMJ, tinnitus, occipital neuralgia, anxiety, migraines are causally related to the October 23, 2012 accident.

The Arbitrator finds the Petitioner's testimony was not credible. The Arbitrator notes that Petitioner was not diagnosed with a concussion, post-concussion syndrome nor did she report any concussion related symptoms to Dr. Patel, Dr. Celmer or Dr. Hsu. Petitioner reported to Dr. Patel that she was only experiencing ear pain and hearing loss. When Petitioner saw Dr. Celmer, on October 24, 2012 and December 5, 2012, Petitioner only complained of right ear pain and a sore nose. Dr. Celmer's records state that Petitioner had no other complaints. Petitioner did not report any concussion related symptoms to Dr. Hsu when she saw him on December 18, 2012, January 22, 2013, February 21, 2013 and March 7, 2013. (PX 13).

Petitioner testified that during the October 23, 2012 incident she hit her head on the wall and blacked out. (T. 14-15). The Employee's Report of Injury, completed by Petitioner, does not state that she hit her head on a wall and blacked out. Petitioner reported only pain in the ear, cheek, right eye on the Employee's Report of Injury. Denise Polick, a co-worker who completed a witness statement, indicated that Petitioner

was hit on the nose and right ear. Ms. Polick's report did not state that Petitioner struck her head on the wall and that she blacked out. On November 16, 2012, Petitioner filed a police report. The report states that Petitioner complained of hearing loss and swelling on the nose. The police report did not state that Petitioner struck her head on a wall and she blacked out. (PX 1). The Arbitrator finds the Employee's Report of Injury, police report and medical histories given to Drs. Patel, Celmer and Hsu to be consistent and conflict with Petitioner's trial testimony.

Petitioner did not report any headache symptoms or concussion related symptoms until she saw Dr. Marzo, on February 13, 2013, who performed a Section 12 examination. The Arbitrator notes that Petitioner did not report to the medical providers that she struck her head struck a wall and blacked out. The Arbitrator also notes that Petitioner did not provide complete medical histories to various doctors regarding her preexisting symptoms, many of which were the same or similar symptoms Petitioner attributed to her work incident. Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicated unreliability. *Gilbert. V. Martin & Bayley/Hucks*, 08 IL.W.C. 004187 (Ill. Indus. Comm'n., 2010).

Petitioner testified that prior to the October 23, 2012 incident she was not taking medication for any reason and could regularly exercise. Petitioner's medical records show that Petitioner treated with Dr. Patel, on April 16, 2012, and was proscribed Topamaz and told to reduce her use of Fioricet. At that time, Petitioner reported that the severity, intensity and frequency of her headaches was increasing. Petitioner reported other symptoms such as fatigue, blurry vision, facial numbness and tingling and difficulty completing sentences. Two years earlier, Petitioner was complaining of migraines, tingling involving the left side of her face, eye, tongue, necks and down her arm as well as blurry vision in the left eye and that she is very fatigued even with minimal activity. The Arbitrator finds that Petitioner's testimony regarding the condition of her health prior to the October 23, 2012 incident was not credible.

The Arbitrator finds the opinions of Drs. Landre and Obolsky to be persuasive. The Arbitrator does not find the opinions of Drs. Sayyad, Mehta, Jordania to be persuasive. The Arbitrator also does not find the diagnoses, related to concussion, post-

concussion syndrome and PTSD, in the Central DuPage Hospital medical records to be persuasive. The Arbitrator finds that those opinions were based upon inaccurate histories or information provided by Petitioner. It is axiomatic that the weigh accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-515 (First Dist. 2000).

Petitioner advised Dr. Mehta that she was previously diagnosed by a neurologist, Dr. Cheng, with a concussion and post-concussion syndrome. Petitioner did not place Dr. Chang's records into evidence. The Arbitrator notes that none of Petitioner's initial treating physicians diagnosed a concussion, post-concussion syndrome, TMJ or PTSD after the October 23. 2012 incident.

The Arbitrator finds that Petitioner failed to prove that she sustained a concussion or post-concussion syndrome after the October 23, 2012 incident. The medical records of Drs. Patel, Celmer, and Hsu do not support that Petitioner suffered a concussion or post-concussion syndrome after the October 23, 2012 incident nor do the records reference that Petitioner experienced concussion related symptoms. Dr. Celmer's records state that Petitioner had no other complaints other than ear pain and hearing loss.

The Arbitrator does not find the testimony of Dr. Sayyad to be persuasive. Dr. Sayyad testified that he was not aware the Petitioner previously treated for headaches and he did not review Petitioner's neuropsychological testing and he only reviewed Petitioner's medical records from Marianjoy. The Arbitrator notes that Dr. Sayyad could not offer an opinion as to Petitioner's current condition of ill-being because he had not examined Petitioner in more than two years prior to his testimony.

The Arbitrator finds the opinions of Drs. Landre and Obolsy persuasive. The Arbitrator notes that both doctors reviewed Petitioner's medical records, examined Petitioner, and reviewed her neuropsychological testing. Dr. Obolsky diagnosed Petitioner as malingerer. Dr. Obolsky opined that Petitioner did not suffer PTSD. Dr. Obolsky based his opinion upon the medical records, psychological testing and neurocognitive testing. Dr. Obolsky testified that the neurocognitive testing showed that Petitioner was malingering and exaggerating her cognitive complaints. On the RBANS test, Petitioner scored in the .01 percentile similar to people who are in severe end-state

dementia. The Arbitrator notes that at the time of the testing, Petitioner was taking and passing college classes. Dr. Obolsky testified the MMPI-2 test showed that Petitioner was exaggerating her physical symptoms.

Dr. Obolsky also opined that Petitioner did not suffer a concussion or post-concussion syndrome. Dr. Obolsky testified that Petitioner did not have any of the four symptoms needed to properly diagnose a concussion. Dr. Obolsky testified to diagnose a concussion you must immediately exhibit one of four symptoms (i.e. loss of consciousness, mental state changes, post-traumatic amnesia or focal neurological signs). Dr. Obolsky found that Petitioner did not have any of the four symptoms immediately after either work accident.

Dr. Landre opined that Petitioner's complaints were not causally related to her work injury and were being maintained by other factors such work avoidance or financial renumeration. Dr. Landre opined that Petitioner's performance on some of the standard cognitive test were improbably low and were at a level typically seen in patients with severe brain injuries or advanced dementia.

Dr. Landre also opined that Petitioner's complaints and course of recover, with delayed onset of many symptoms, and little or no improvement and/or worsening of alleged injury-related symptomatology are inconsistent with her injuries. Dr. Landre opined that Petitioner's cognitive tests and results and responses to self-reporting measures reflect probable symptom magnification. (RX 1).

Dr. Sayyad testified that when Petitioner started treating at Marianjoy she complained of blurred vision in the left eye, headaches, sensitivity to light and problems with attention and memory all the result of being punched in the head in October of 2012.

On April 16, 2012 and August 23, 2010, prior to the October 23, 2012 incident, Petitioner reported symptoms of blurry vision in the left eye, migraines increasing in frequency and duration, sensory changes, tingling down the left side of her face, difficulty talking and felt fatigued. (PX 12)

The Arbitrator notes the symptoms Petitioner's claims were related to her October 23, 2012 incident existed prior that incident and that Petitioner failed to fully report these preexisting symptoms to her treating physicians. The Arbitrator further finds that Petitioner's actions supports the opinions of Dr. Obolsy who testified that after reviewing

the results from the psychological testing, Petitioner was misattributing causation Petitioner was piling up every symptom she can think of, whether it's present or not, and claim they were all caused by either the first or second injury. (PX 4).

In support of the Arbitrator's decision relating to issue, (J), has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

An examination of the bills in petitioner's medical bills exhibit reveals that all medical bills related to the October 23, 2012, incident are satisfied. (PX 9). Therefore, petitioner is awarded no additional benefits for unpaid medical bills. *Id.*

In support of the Arbitrator's decision relating to issue, (L), what is the nature and extent of the injury, the Arbitrator finds the following facts:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant

> of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of Section 8.1b(b), the 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 8.1b(b), the occupation of the injured employee, the evidence established that Petitioner was a health assistant in a school with children with behavior disorders and physical limitations. As such, it is reasonable to assume, Petitioner would continue to be at risk of being hit or struck by a child with behavior issues. Therefore, the Arbitrator find that this factor increases the amount of permanency.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, the evidence established that Petitioner was 35 years old on the date of the accident. As employees age, the body becomes less capable of recovering from injuries as someone younger than Petitioner. As such, the Arbitrator finds that this factor only slightly increases the amount of Permanency.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator finds that Petitioner is capable of returning to work without restrictions but that has not for reasons unrelated to her work accident. As such, the Arbitrator finds that this factor has no impact upon the amount of permanency.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, Petitioner testified to symptoms unrelated to her work accident. The Arbitrator finds that Petitioner's testimony, regarding evidence of disability, was not corroborated by the treating medical records. Petitioner suffered a 20% perforation of her eardrum, which was repaired. Tests conducted weeks after the surgery show that Petitioner's hearing was normal. Petitioner did make some soft-tissue

complaints of pain involving her neck and nose. As such, the Arbitrator finds that this factor lessens the amount of permanency.

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, the Arbitrator finds that Petitioner suffered permanent partial disability of 10% loss of use of man as a whole pursuant to Section 8(d)(2) of the Act, at the applicable minimum permanent partial disability rate, for this date, of accident of $319.00.

In support of the Arbitrator's decision relating to issue, (N), is Respondent due any credit, the Arbitrator finds the following facts:

Pursuant to the agreement made by the parties on the record at the commencement of this trial, the Arbitrator elects to apply Respondent's credit for the permanent partial disability advance to Petitioner's other case, 13 WC 13676, as the Parties assumed it may have greater permanency value.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC013676
Case Name	WELLMAN,JACLYN v. CASE: GLENWOOD ACADEMY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0403
Number of Pages of Decision	59
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	David Menchetti
Respondent Attorney	Peter Stavropoulos

DATE FILED: 8/9/2021

/s/Deborah Baker, 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 Causal Connection, Medical, TTD, PPD	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACLYN WELLMAN,

Petitioner,

vs. NO: 13 WC 13676

CASE: GLENWOOD ACADEMY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of whether: the date of accident is correct, the benefit rates are correct, the wage calculations are correct, Petitioner's current condition of ill-being is causally connected to the accident, Petitioner is entitled to medical expenses both previously incurred and prospective, Petitioner's previously incurred medical treatment was reasonable and necessary, Petitioner is entitled to temporary disability benefits, Petitioner is entitled to permanent disability benefits, and "clerical errors," 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.

I. HISTORY & SUMMARY

Petitioner filed two claims alleging injuries while employed by Respondent: 13 WC 13675 (acute trauma on October 23, 2012); and 13 WC 13676 (acute trauma on March 19, 2013). Both matters were consolidated for hearing. At the hearing, the parties stipulated that both accidents arose out of and in the course of her employment with Respondent. The Arbitrator thereafter issued two separate decisions.

In case no. 13 WC 13675, the Arbitrator found Petitioner's perforated right eardrum and neck pain were causally related to the undisputed October 23, 2012 accident where a student punched Petitioner. The Arbitrator found further that Petitioner failed to prove she sustained a concussion, post-concussion syndrome, PTSD, TMJ, tinnitus, occipital neuralgia, anxiety, and migraines as a result of the October 23, 2012 accident. The Arbitrator found Respondent had paid all associated medical bills and thus awarded no medical benefits. The parties stipulated that temporary total disability ("TTD") benefits were not at issue in this case. The Arbitrator found Petitioner's injuries caused a 10% loss of the person-as-a-whole pursuant to section 8(d)(2) of the Act.

In case no. 13 WC 13676, the Arbitrator found Petitioner failed to prove she sustained a concussion, post-concussion syndrome, PTSD, TMJ, tinnitus, occipital neuralgia, anxiety, and migraines that were causally related to the undisputed March 19, 2013 accident where a student pushed and hit Petitioner for a second time. The Arbitrator found Petitioner's unspecified condition had resolved as of August 19, 2013 based on Dr. Landre's section 12 examination opinions and awarded medical and TTD benefits through August 19, 2013. The Arbitrator further found Petitioner's injuries caused a 7.5% loss of the person-as-a-whole pursuant to section 8(d)(2) of the Act. The Arbitrator noted the parties stipulated Respondent was entitled to a credit for TTD benefits and an advance in PPD benefits totaling $14,507.77.

The Commission agrees with the Arbitrator, in part, and finds Petitioner failed to prove that the TMJ, tinnitus, and occipital neuralgia conditions were caused by either the undisputed October 23, 2012 or the March 19, 2013 accidents. However, the Commission disagrees with the Arbitrator, in part, and finds Petitioner proved by a preponderance of the evidence that: (1) the undisputed accidents caused Petitioner to suffer concussions and post-concussion syndrome, which resolved by July 18, 2013; (2) the undisputed accidents aggravated Petitioner's migraines and resolved by July 18, 2013; (3) the undisputed accidents caused Petitioner to suffer PTSD, which resolved by September 20, 2016; and (4) the undisputed accidents aggravated and exacerbated Petitioner's anxiety and depression, which resolved by September 20, 2016.

II. ADDITIONAL FINDINGS OF FACT

In September 2007, Petitioner began working as a health assistant for Respondent, Cooperative Association for Special Education ("CASE")/Glenwood Academy. T. 10. Petitioner explained Glenwood Academy includes kindergarten through 12th grade, and all the students have a mental disability, physical disability, or behavioral problem. T. 13. Petitioner's job was to provide for the health needs of the students: she administered medication as needed; prepared health files for Individualized Education Plan meetings; and participated in daily or weekly meetings with each student and his/her social worker, psychologist, and physician. T. 11. She would accompany the students on certain field trips if medication issues made it necessary. T. 12. Petitioner is trained in Crisis Prevention and Intervention, and she assisted students who had trouble performing certain activities. T. 12. She was also a paraprofessional for the school, so she assisted students during physical education and helped in classrooms that were short-staffed. T. 12.

On August 23, 2010, Petitioner presented to her family physician, Dr. Sapan Patel at DuPage Medical Group's Wheaton Medical Clinic. Petitioner reported numbness and tingling in her left side face and arm for approximately three years. Petitioner also reported having severe headaches on the left side with blurry vision, anxiety when her migraines progressed, and fatigue. Dr. Patel diagnosed Petitioner with numbness and tingling, chronic left-sided headaches, and fatigue and recommended that Petitioner undergo an MRI of the brain to rule out a mass or other structural abnormality. Dr. Patel referred Petitioner to neurology for possible complex migraines. On August 30, 2010, Petitioner underwent an MRI of the brain which was within normal limits. Pet.'s Ex. 1; Pet.'s Ex. 12.

On April 16, 2012, Petitioner returned to Dr. Patel and reported that her migraines were getting worse over the last couple of months and she experienced facial numbness, blurry vision, tingling and sensory changes when she had severe migraines. Petitioner also reported a deep pain in the head that she had not experienced before. Dr. Patel noted that she had no focal abnormalities on a comprehensive neuro exam and diagnosed Petitioner with chronic migraines. Dr. Patel recommended Petitioner undergo a CT of the brain and blood work, and adjusted Petitioner's medication, opining that one medication may have been contributing to Petitioner's "rebound symptoms." Petitioner underwent the CT scan of the brain that same day, which was unremarkable. Pet.'s Ex. 12.

The October 23, 2012 Undisputed Accident

The parties stipulated that Petitioner sustained an accidental injury arising out of and occurring in the course of her employment on October 23, 2012. Arb.'s Ex. 1. Petitioner testified she was exiting a classroom in the elementary wing, having just administered medication to a student, when she encountered a classroom aide and another student in the hallway; the student was yelling that he had been punched by a fellow student, and the aide was walking him to Petitioner's office to get an ice pack. T. 14. Petitioner explained the protocol is that students in any kind of crisis are supposed to have three staff members with them, but the classroom aide left Petitioner alone with the student and "when I was asking him how did this happen, how he was hurt, he was yelling and swearing and then he started punching me." T. 14. Petitioner explained the student struck her with a fist using both hands. Petitioner also testified that the student punched her on the bridge of her nose, in the mouth, in the right ear, and jaw. Petitioner testified that she could not hear immediately after the student punched her in the ear. Petitioner testified further that she hit hear head on the wall and blacked out after being punched. T. 15. Petitioner testified the student was a first grader; he weighed 50 or 60 pounds and his height was below Petitioner's shoulder level. T. 15-16. Petitioner is 5'1" and she weighed approximately 110 pounds at that time. T. 16. Petitioner testified that she reported the incident. T. 16.

Petitioner sought medical care that day at DuPage Medical Group's Wheaton Medical Clinic where she was evaluated by Dr. Patel who had treated Petitioner previously. Pet.'s Ex. 12. Dr. Patel memorialized that Petitioner reported being punched in the face by a student, with blows landing on her forehead, nose, and right ear, and complained of ear pain and decreased hearing on the right side. Pet.'s Ex. 12. The doctor noted Petitioner denied vision changes and loss of consciousness. Pet.'s Ex. 12. Dr. Patel's physical examination revealed no large contusions to the head and facial bones stable to palpation, however the right tympanic membrane had a central

perforation. Pet.'s Ex. 12. Diagnosing a traumatic right ear perforation, Dr. Patel prescribed Cipro ear drops and referred Petitioner for evaluation by an ear, nose, and throat specialist. Pet.'s Ex. 12. At trial, Petitioner testified she continued working after the injury. T. 29.

On October 24, 2012, Petitioner was evaluated by Dr. Andrew Celmer, an otolaryngologist. Pet.'s Ex. 3. Dr. Celmer noted Petitioner had been referred by Dr. Patel for right tympanic membrane perforation. Pet.'s Ex. 3. Petitioner provided a consistent history of the altercation the day before followed by sudden ear pain and hearing loss; Petitioner also indicated she was struck in the nose and complained her nose was sore, but her breathing was unaffected. Pet.'s Ex. 3. Following an examination, Dr. Celmer diagnosed traumatic right ear perforation with conductive hearing loss as well as nasal trauma without evidence of fracture. Pet.'s Ex. 3. Dr. Celmer attempted a paper patch myringoplasty, but Petitioner could not tolerate the procedure so the doctor instead recommended dry ear precautions with the hope the tympanic membrane would heal on its own. Pet.'s Ex. 3.

That same day, Petitioner completed an Employee Report of Injury. Pet.'s Ex. 1. Therein, Petitioner memorialized that she was attempting to calm a student when he "punched me in the forehead, nose, and [right] temporal area/ear." Pet.'s Ex. 1. A witness statement prepared by Denise Polick reflects Petitioner was struck repeatedly in the nose and the ear area. Pet.'s Ex. 1.

On November 16, 2012, the incident was reported to the Glendale Heights Police Department. The report reflects Petitioner was punched three times in the nose and three times in the temporal/ear area. Pet.'s Ex. 1. The responding officer memorialized Petitioner wanted to document the incident but did not wish to pursue a complaint. Pet.'s Ex. 1.

On December 5, 2012, Petitioner was re-evaluated by Dr. Celmer, who noted dry ear precautions had been unsuccessful: there had been no closure of the perforation and Petitioner had persistent hearing loss and right ear pain. Concluding Petitioner likely required formal tympanoplasty, Dr. Celmer referred Petitioner to Dr. Griffith Hsu for an otology consultation. Pet.'s Ex. 3.

At trial, Petitioner testified that in the weeks after her accident, in addition to her ear symptoms, she also had pain in her teeth and jaw. T. 18. Pursuant to a referral from Dr. Ismail, Petitioner consulted with Gregory Doerfler, D.D.S., on December 14, 2012. T. 18. Dr. Doerfler noted Petitioner complained of pain with function as well as "popping" on the right side after being struck three times in the right side of the face; Petitioner did not lose consciousness but did slide to the floor, and over the next hours, her jaw stiffened up. Cone-bean CT dental imaging was completed and was negative for significant osseous or soft-tissue abnormality, and Dr. Doerfler indicated further imaging should be considered. Pet.'s Ex. 11.

On December 18, 2012, Petitioner was evaluated by Dr. Hsu. Upon examining Petitioner's tympanic membrane perforation and conducting an audiogram and tympanogram, Dr. Hsu recommended proceeding with tympanoplasty. Pet.'s Ex. 13. On January 7, 2013, Dr. Hsu performed a right tympanoplasty and right allograft reconstruction. Pet.'s Ex. 13. Post-operatively, Petitioner attended routine follow-up appointments with Dr. Hsu.

On February 11, 2013, Petitioner was evaluated pursuant to §12 by Dr. Sam Marzo. T. 28-29. Petitioner gave a history of being hit in the head with a fist multiple times in October 2012. She was thereafter diagnosed with a perforated tympanic membrane and underwent a tympanoplasty in January. She advised she was recently seen by a neurologist who diagnosed post-concussive syndrome as well as occipital neuralgia and performed a nerve block, and Petitioner had further been told she has TMJ. Upon examination and hearing tests, Dr. Marzo's diagnoses included central perforation of tympanic membrane; post-concussion syndrome; conductive hearing loss, tympanic membrane; subjective tinnitus; otogenic pain; ear pressure; and temporomandibular joint disorders, unspecified. Dr. Marzo noted Petitioner's right ear appeared to be healing nicely and recommended she undergo an audiogram as soon as it healed completely. The doctor observed Petitioner's pain and tinnitus should improve with time. Dr. Marzo further recommended Petitioner continue TMJ treatment as well as neurologic management of her post-concussive syndrome. Pet.'s Ex. 16.

At the March 7, 2013 follow-up with Dr. Hsu, Petitioner indicated she continued to experience muffled hearing. On examination, Dr. Hsu observed Petitioner's tympanic membrane was intact; an audiogram revealed Petitioner's right conductive hearing loss had resolved. Dr. Hsu released Petitioner from care. Pet.'s Ex. 13.

That same day, March 7, 2013, Dr. Karen Levine performed a neurological evaluation of Petitioner at Respondent's request. The record reflects Dr. Levine opined Petitioner's pre-existing migraines could have been aggravated by the work injury, and the doctor recommended further workup with an MRI; Dr. Levine's diagnosis was mild post-concussion syndrome. Resp.'s Ex. 4.

The March 19, 2013 Undisputed Accident

The parties stipulated that Petitioner sustained a second accidental injury arising out of and occurring in the course of her employment on March 19, 2013. Arb.'s Ex. 2. Petitioner testified she was attacked while in an elementary classroom to administer medication:

> And I went to one student to give him his medication; and I bent down to give it to him and another thought that it was his turn for medication and it was not, so he got angry and was yelling and swearing at me and he ran out of the classroom. So the classroom assistant ran out after him and I could not leave the room with the other students in it, they can't be alone. So I finished what I was doing with the other students and their medication, and the student that ran out of the room came back in the room running and swearing at me. And my back was to the area he was coming from. He punched me in the middle of my back, jumped on my back, started punching me in the neck and in my head, the back of my head. And I tried to get him off me and he kept punching me, and I hit the wall in the front and blacked out and had to have somebody walk me to my office. I couldn't walk straight. T. 21-22.

The student was eight years old and weighed 60 or 70 pounds; he punched Petitioner with both fists. T. 22. Petitioner explained her forehead and face hit the wall before she blacked out. T. 22.

Petitioner sought treatment that day at the Central DuPage Hospital emergency room where she was seen by Kerri Manning, PA-C, and Joseph Boyle, D.O. The records reflect Petitioner presented with a chief complaint of concussion and provided the following history:

> The patient is a 35-year-old female who comes in today after an injury at work. The patient in October was punched by a student at an alternative school, where she works at and sustained a pretty significant concussion with a ruptured tympanic membrane. She supposedly suffers from postconcussive syndrome and has been under the care of Dr. Cheng of neurology. She continues to have headaches and some occipital neuralgia. The patient has been back at work and today was hit from behind by a student and punched in the occiput. Has worsening head pain and dizziness as well as nausea at this time. There is no loss of consciousness, no numbness, tingling, or weakness anywhere. The patient took Fioricet with no relief of her pain. Pet.'s Ex. 15.

Examination findings included normocephalic and atraumatic head; pupils equal, round, and reactive to light; and Petitioner was alert and oriented to person, place, and time with normal mood and affect. After diagnostic workup, Dr. Boyle's impression was as follows:

> Pt with neg. CT. Pt with new concussion. Unfortunately, the pt. Has [*sic*] post-concussive syndrome from a head injury a few months ago. Pt seems to be suffering from PTSD from first concussion. Pt met with social worker who assisted with f/u for this pt. Pt given new neurologist as well. Pet.'s Ex. 15.

Petitioner was authorized off work for the remainder of the week and discharged with instructions to follow-up with her primary care physician. Pet.'s Ex. 15. Petitioner testified she has not worked since the March 19, 2013 accident. T. 30.

The next day, March 20, 2013, Petitioner completed an Employee's Report of Injury. Petitioner memorialized that a student ran into the classroom "and pushed me in the back and hit the back of my head, my head whipped back," and identified injuries to her head, neck, back, and another concussion. Pet.'s Ex. 1.

Petitioner testified that while she was under the care of Dr. Cheng, she underwent some injections. Ultimately, however, Dr. Cheng referred her to Marianjoy for further evaluation and treatment with a brain injury specialist. T. 24.

On April 11, 2013, Petitioner consulted with Dr. Sachin Mehta at Marianjoy Medical Group. The records reflect Petitioner's chief complaint was post-concussion neuro behavioral deficit, neuro cognitive deficit, impaired balance, visual spatial, headache, and insomnia. The two work injuries were detailed in the history of illness and Petitioner's current symptoms were as follows:

> She [complains of] TROUBLE WITH "FLIPPING LETTERS, NUMBERS, DIRECTIONS", CALCULATING DIFFICULTIES. HER HUSBAND NOTED THAT SHE WROTE "NAVERPILE INSTEAD OF NAPERVILLE." SHE

> STATES SHE IS MORE IRRITABLE, LESS TOLERANT OF HER KIDS [*sic*] ACTIONS. SHE [CONTINUES TO COMPLAIN OF] CONSTANT [HEADACHES] AND [BILATERAL] EYE TWITCHING. SHE RECEIVED AN [RIGHT] OCCIPITAL NERVE BLOCK BY DR. CHANG [*sic*] WHICH IMPROVED THE [RIGHT] EYE TWITCHING BUT ONLY HELPED [HEADACHE] FOR 3-4 DAYS.
> HER MOOD IS DOWN. SHE FEELS NERVOUS AND ANXIOUS. SHE STATES SHE HAS BEEN TOLD SHE HAS PTSD. SHE [COMPLAINS OF] FEELING FATIGUED MOST OF THE DAY AS WELL AS JITTERY. APPETITE IS POOR AND SHE MUST FORCE HERSELF TO EAT BUT THEN DEVELOPS NAUSEA.
> SHE FEELS LOSS OF CONTROL OVER HER LIFE. IN ADDITION TO WORKING 37 HOURS/WEEK, SHE WAS ALSO ATTENDING CLASSES 2-6 HOURS/WEEK. HER HUSBAND IS ON DISABILITY AND CANNOT WORK OR HELP MUCH RUN THE HOUSE. SHE IS THE PRIMARY CAREGIVER FOR HER CHILDREN. Pet.'s Ex. 8 (Emphasis in original).

The Post-Concussion Physical Exam findings included tenderness to the neck/upper back and right occipital nerve, decreased neck range of motion, slow and guarded gait, abnormal balance, and mild convergence deficits; cognition findings included recent and remote memory intact, lethargy, anxiety, depression, and flat affect. Petitioner was noted to be anxious and tearful throughout the examination. Dr. Mehta's assessment was post-concussion syndrome, neurobehavioral deficits/neurocognitive, impaired balance, insomnia, anxiety/depression/PTSD, and chronic post-concussion headaches. The treatment recommendation was multifaceted. For the post-concussion syndrome, Dr. Mehta recommended enrollment in the post-concussion day rehab program with therapy for vestibular dysfunction, visual-spatial deficits, and neurocognitive deficits; a neuropsychology evaluation prior to initiating therapy to assist with coping and validity assessment; and a neuro-optometry evaluation for visual-spatial deficits. Noting Petitioner had a pre-existing history of mild depression likely exacerbated by multiple assaults/concussions, Dr. Mehta referred Petitioner to Dr. Jordania, a neuropsychiatrist, and to neuropsychology to address Petitioner's depression/anxiety. Dr. Mehta prescribed Nortriptyline, Xanax, and Melatonin for Petitioner's insomnia; Ritalin for her daytime fatigue; and Nortriptyline and Fioricet for headaches. Finally, Dr. Mehta authorized Petitioner off work and directed her not to drive. Pet.'s Ex. 8.

On April 15, 2013, Petitioner presented to the Glen Oaks Hospital emergency room complaining of an onset of left paresthesia and altered speech 20 minutes prior. Dr. Daniel O'Reilly consulted and noted Petitioner had developed a right-sided headache followed shortly thereafter by numbness on the left side of her tongue and lip with some slurred speech and then developed numbness in her left arm and her left leg. It was further noted Petitioner had a prior history of being punched in the face with brief loss of consciousness in October as well as a second assault in March, and she was in treatment for post-concussion syndrome, which she described as headache which was constant since October, frequent nausea, postural dizziness, and difficulty with her balance. Petitioner was worked up for possible stroke with a CT and MRI of the head/brain; when the testing was negative for TIA, Petitioner was discharged with instructions to follow-up with her neurologist and primary care physician. Pet.'s Ex. 14.

On April 22, 2013, Dr. Nina Jordania performed an initial psychiatric evaluation of Petitioner as recommended by Dr. Mehta. The record reflects Petitioner reported headaches with photo and phonophobia, jumpiness and nervousness, and feeling very anxious and fearful dating back to her first concussion. Petitioner also reported poor balance, difficulty focusing, fear of being alone with strangers, nightmares, constantly rewinding the events, hypervigilance, as well as multiple somatic symptoms. Dr. Jordania's assessment was anxiety due to medical condition (post-concussive syndrome) and PTSD, insomnia due to PTSD, and post-concussive syndrome. Dr. Jordania discussed psychoeducation strategies and adjusted Petitioner's medications. Pet.'s Ex. 6.

In late April and early May, Respondent conducted surveillance of Petitioner. The Commission has reviewed the video offered into evidence as Respondent's Exhibit. 6.

On April 30, 2013, Petitioner commenced therapy through Marianjoy's day rehab program. Over the next several weeks, Petitioner attended approximately twice weekly occupational, physical, and speech therapy. Pet.'s Ex. 7.

At the May 16, 2013 follow-up appointment with Dr. Mehta, Petitioner reported she was making progress with therapy; she continued to have constant right-sided headache but was learning strategies to manage the pain. Dr. Mehta noted the therapy staff reported Petitioner's headaches were slightly improved, her overall balance was better, her tolerance for eye movements was improved, and she had improved attention and executive functioning, especially with structured tasks with breaks. Dr. Mehta further noted Petitioner underwent a neuropsychological evaluation with Dr. Devereux, and Petitioner indicated there were problems with computer color, which could affect Petitioner's performance. Dr. Mehta spoke with Dr. Devereaux, who indicated Petitioner performed on the test as poorly as someone who has Alzheimer's although she does not function in her daily life as someone who does have Alzheimer's disease. Dr. Mehta adjusted Petitioner's Ritalin dosing and directed Petitioner to continue with the comprehensive day rehab program as well as follow-up with Dr. Jordania. Pet.'s Ex. 8.

Over the next weeks, Petitioner underwent further therapy at Marianjoy and also saw Dr. Jordania, who adjusted Petitioner's medication. Pet.'s Ex. 6.

On June 6, 2013, Petitioner presented to Dr. Hsu; the record reflects Dr. Celmer requested the consultation to evaluate Petitioner's complaints of balance problems, ringing in both ears, and decreased hearing on the right. A hearing assessment was performed and revealed a slight decrease to thresholds compared to the March 17, 2013 assessment. Dr. Hsu's assessment was tinnitus most likely secondary to concussion and unspecified hearing loss. Petitioner was directed to return if her symptoms failed to improve. Pet.'s Ex. 13.

Petitioner was discharged from speech therapy on June 13, 2013. The speech language pathologist documented Petitioner demonstrated independent use of strategies. Pet.'s Ex. 7. The next day, June 14, Petitioner was discharged from occupational therapy. The discharge summary reflects Petitioner had achieved all therapy goals but had remaining impairments and limitations:

> [Patient] with good progress in OT meeting all goals set at evaluation. Patient has demonstrated a steady improvement in her ability to return to IADL and community

> level tasks by implementing strategies learned in OT to reduce stimulation and reduce exacerbation of post concussive symptoms. [Patient] demonstrates improved ocularmotor function with only mild impairment with movements to outer areas of the visual field only rarely. Patient is now able to turn her eyes and head to see her full environment without increased symptoms during her sessions in the clinic. Patient still fatigues more quickly than baseline but with good planning she can manage this to maximize her productivity. Her area of greatest limitation is still in navigating a large, busy area in the community for tasks that require greater amounts of visual scanning and locating items such as during grocery shopping. [Patient] also does still have headache pain although it is more manageable at a 4/10 or less most times. Pet.'s Ex. 7.

On June 21, 2013, Petitioner underwent a driver rehabilitation evaluation at Marianjoy. The occupational therapist opined Petitioner demonstrated the necessary skills for independent driving and no further sessions were indicated. Pet.'s Ex. 5, Pet.'s Ex. 7.

Petitioner was re-evaluated by Dr. Mehta on July 2, 2013. Dr. Mehta noted Petitioner completed the day rehab program and transitioned to a home exercise program; it was further noted Petitioner finished seeing Dr. Devereux who diagnosed Petitioner with PTSD. Dr. Mehta concluded Petitioner was steadily improving from a concussion standpoint but continued to have significant PTSD symptoms. Dr. Mehta recommended Petitioner continue seeing Dr. Jordania for medical management of her PTSD and also referred her to a psychologist specializing in post-traumatic stress counseling. Pet.'s Ex. 5, Pet's Ex. 8.

At the July 18, 2013 follow-up appointment with Dr. Jordania, Petitioner reported significant improvement in her headaches, but her PTSD was still very symptomatic. She described persistent fear of children and people in public places as well as fear of being attacked. Dr. Jordania diagnosed anxiety due to medical condition (post-concussive syndrome), PTSD, and insomnia due to PTSD, and adjusted Petitioner's medications. Pet.'s Ex. 6. On July 23, Dr. Jordania authored a letter indicating Petitioner was unable to work due to post-concussion symptoms. Pet.'s Ex. 5.

Pursuant to Dr. Mehta's referral, Petitioner sought treatment at Pathways Psychology Services; the initial consultation with Steve Cromer, L.C.P.C., took place on July 31, 2013. Diagnosing PTSD and concussions - beat up at work, Cromer recommended individual therapy to address Petitioner's PTSD and fear/anxiety. Pet.'s Ex. 5. Petitioner attended therapy sessions with Cromer for the next several months. Pet.'s Ex. 5.

On August 19, 2013, Dr. Nancy Landre performed a neuropsychological evaluation pursuant to §12 at Respondent's request. Dr. Landre's report reflects Petitioner's performance on the symptom validity assessment was abnormal, indicating the cognitive test results were not valid for interpretation as they likely portrayed her as much more impaired than she was. Dr. Landre noted Petitioner's level of performance on some standard cognitive indices was improbably low, at a level typically seen in patients with severe brain injuries or advanced dementia. Dr. Landre concluded as follows: "Available evidence, therefore, suggest that factors other than the injury itself underlie Ms. Wellman's continued complaints. Petitioner is capable of resuming full-time

work activity without any restrictions at this time. No further recommended treatment." Resp.'s Ex. 1.

A week later, on August 26, 2013, Dr. Mehta authored a note indicating Petitioner remained under his care for post-concussive syndrome complicated by post-traumatic stress symptoms and was unable to return to work. Pet.'s Ex. 5.

Over the next two months, Petitioner remained off work and attended counseling sessions with Cromer and follow-up appointments with Dr. Mehta and Dr. Jordania. At the November 4, 2013 re-evaluation with Dr. Mehta, Petitioner reported continuing difficulties with headaches, dizziness with certain movements, and anxiety; Petitioner described experiencing agoraphobia, flashbacks, and trouble sleeping, with occasional nightmares. Petitioner advised the doctor that she hoped to return to work but was unable to go back to her previous job, and she inquired about other options. Dr. Mehta directed Petitioner to continue seeing Dr. Jordania and her counselor, and ordered a vocational assessment:

> We did write an order for vocational counseling to assess her current condition. She is unable to return to her previous job. I would like her to have some idea as to other options that she can tolerate. She has significant PTSD, which may prevent her from returning to the previous job. She also continues to have some neurobehavioral, neurocognitive deficits at this time. Therefore any type of return to work, she would need a full neuropsychology battery. Pet.'s Ex. 8.

The doctor further documented he was leaving Marianjoy, and Petitioner's care would thereafter be overseen by Dr. Sayyad. Pet.'s Ex. 8.

On November 11, 2013, Petitioner met with Ken Skord, M.S., C.R.C., for a vocational rehabilitation consultation. Skord documented Petitioner's vocational history included EMT certification, certified phlebotomist, CNA, certification to perform school vision and hearing screenings, and licensed cosmetologist; Petitioner additionally had paramedic training and had nearly completed an AA degree in science. Pet.'s Ex. 7. Vocational barriers were identified as post-traumatic stress disorder, ruptured eardrum, hand tremors, migraine headaches, jaw problems, eye problems, depression, and anxiety. Petitioner reported she wished to work again but expressed significant fears and concerns about returning to work to her current employer or similar work. She indicated she was contemplating applying for a part-time position as a breast-feeding counselor assisting women who want and need training, as she has interest and previous training in this area. Skord encouraged Petitioner to contact him if she wished to pursue formal vocational evaluation and counseling and provided her with a resource for finding volunteer opportunities. Pet.'s Ex. 7.

Follow-up appointments with Dr. Jordania and counseling sessions with Cromer continued through the end of 2013 and into 2014. On January 30, 2014, Petitioner presented for an initial evaluation with Dr. Anjum Sayyad. Dr. Sayyad noted Petitioner's past medical history was significant for post-concussive syndrome with posttraumatic stress disorder, associated with neurobehavioral deficits. Petitioner recently had her Ritalin increased and reported improvement in her attention and concentration; however, she continued to have poor sleep, light and sound

sensitivity, hypervigilance, memory problems, and dizziness with position changes. Dr. Sayyad's impression was ADL mobility dysfunction with neurocognitive and neurobehavioral deficits associated with post concussive syndrome and PTSD. The doctor recommended continued treatment with Dr. Jordania and authorized Petitioner to remain off work. Pet.'s Ex. 4.

Over the next several months, Petitioner underwent regular counseling with Cromer and attended routine follow-up appointments with Dr. Jordania and Dr. Sayyad. Pet.'s Ex. 5, Pet.'s Ex. 6, Pet.'s Ex. 7. In May 2014, Petitioner reported she completed two classes but did not feel that she did well. Dr. Sayyad's nurse practitioner, Sylvia Duraski, APN, encouraged Petitioner to take another class, indicating speech therapy could be ordered to assist with Petitioner's attention and memory deficits. When Petitioner followed up on September 4, 2014, she reported she had taken additional classes but failed both; APN Duraski directed Petitioner to continue treatment with Dr. Jordania and counseling with Cromer, and also ordered speech therapy to help Petitioner in her classes. Petitioner was to remain off work and neuropsychological testing was ordered to assess whether Petitioner was ready to return to work. Pet.'s Ex. 4, Pet.'s Ex. 8.

The recommended therapy evaluation took place on November 13, 2014. The therapist concluded Petitioner required skilled speech language pathology services to facilitate functional cognitive communication skills to enable safety and independence with daily tasks and responsibilities at home, in the community, and at work. A course of three sessions per week for four to six weeks was recommended. Pet.'s Ex. 7. Petitioner started therapy on November 25, 2014 and continued through the end of the year.

On December 31, 2014, Dr. Alexander Obolsky issued a report summarizing the psychiatric examination of Petitioner he conducted pursuant to §12 at Respondent's request. Petitioner had undergone testing at Dr. Obolsky's direction on April 29, 2014 and met with him on May 16, 2014. Dr. Obolsky concluded Petitioner exhibited malingering as well as avoidant, dependent, and compulsive personality features. Dr. Obolsky opined there was no objective evidence that Petitioner's "alleged work events caused clinically significant mental, emotional, or cognitive dysfunction." Resp.'s Ex. 3. The doctor indicated that during the forensic psychiatric evaluation, Petitioner did not present with behavioral symptoms of anxiety, distress, or avoidance when describing the alleged traumatic events, and she had no difficulties with recall, describing events in detail, and showed neither anxiety nor hyperarousal when recalling and discussing these events. In contrast, on the medical psychiatric questionnaire, she endorsed over 40 current assorted symptoms involving various bodily symptoms, and on forensic psychological testing, Petitioner exaggerated somatic and cognitive complaints and inconsistently magnified psychiatric symptoms. Dr. Obolsky opined Petitioner's observed behaviors during the two days of the evaluation were incongruent with her self-reported subjective complaints. Dr. Obolsky further felt Petitioner's self-report of subjective symptoms was unreliable due to her reporting inauthentic, exaggerated, and inconsistent symptoms. Dr. Obolsky opined Petitioner had been exaggerating her various mental, emotional, and cognitive complaints "as far back as several weeks after the alleged second injury." Resp.'s Ex. 3. Dr. Obolsky believed Petitioner exhibited "life-long maladaptive avoidant, dependent, and obsessive-compulsive personality features." Resp.'s Ex. 3. Dr. Obolsky concluded as follows:

> …Ms. Wellman reports multiple and various subjective mental, emotional, and cognitive symptoms. Her self-report is unreliable as evidenced by exaggeration of

> symptoms, inconsistencies, and discrepancies noted above. There is no objective evidence to support presence of reported symptoms and the alleged causal connection of such symptoms to the work events in 2012 and 2013. On the other hand, Ms. Wellman exhibits a life-long personality features [*sic*] that interfere with her interpersonal functioning leading to dysthymia, anxiety, worries, fears, and somatic complaints. Ms. Wellman has decided not to return to her employment, she is claiming mental, emotional, and cognitive symptoms as justification for remaining off work. Resp.'s Ex. 3.

Dr. Obolsky further concluded Petitioner did not develop post-traumatic stress disorder due to the work events. Resp.'s Ex. 3.

Follow-up treatment with Dr. Jordania and Dr. Sayyad and counseling with Cromer continued into 2015. On April 21, 2015, Petitioner was re-evaluated by Dr. Jordania. Dr. Jordania memorialized that upon Petitioner's initial presentation, Petitioner's symptom complex included problems with sleep, constant headaches with photo and phonophobia, nervousness, heightened anxiety, inability to focus, memory difficulties, nightmares, fear of everything, ringing in her ears, vision problems, and inability to drive due to poor balance. Petitioner's current symptoms were noted to be headaches with increasing sensitivity to different stimuli as the day progresses, persistent ringing in the ears, improved palpitations, and continuing jumpiness but without automatically assuming that it is a bad thing. The doctor observed Petitioner was "very disturbed by the review of independent Neuropsychological evaluation concluding that her presentation and symptoms do not meet the criteria of PTSD not postconcussive syndrome, diagnosing her with Malingering and Somatization." Pet.'s Ex. 6. Upon discussing Petitioner's cognitive and mood status, Dr. Jordania concluded Petitioner had "achieved MMI with the present medication regimen." Pet.'s Ex. 6. Dr. Jordania's assessment remained anxiety due to medical condition (post-concussive syndrome), PTSD, and insomnia due to PTSD; the treatment plan was to "keep her meds as is and add amantadine." Pet.'s Ex. 6.

On July 7, 2015, Petitioner followed up at Marianjoy. The record reflects Petitioner's symptoms were unchanged. Pet.'s Ex. 4.

In early 2016, Respondent obtained a labor market survey. Resp.'s Ex. 5. The February 29, 2016 report indicates appropriate vocational goals for Petitioner include claims clerk, receptionist, collections clerk, hospital-admitting clerk, radio dispatcher, administrative clerk, customer service clerk, home attendant, and teacher aide. The wage range for those positions within a 50-mile radius was $12.00 to $23.00 per hour. Resp.'s Ex. 5.

Petitioner's next follow-up visit at Marianjoy occurred on March 25, 2016. Petitioner reported her headaches were under control since Dr. Jordania increased her Depakote dose; Petitioner continued to get headaches but they did not occur until evening, though the side effect of Depakote was Petitioner got tired in the afternoon. Petitioner further advised she recently resumed taking classes and was enrolled in a criminal investigation class as well as a grief therapy class; she reported the grief class was helping with her PTSD. After discussion with Dr. Sayyad, Petitioner was advised to try a small dose of Amanatadine to address her fatigue. She was

otherwise to continue with the treatment plan of ongoing follow up with Dr. Jordania and the psychologist. Pet.'s Ex. 4, Pet.'s Ex. 8.

On May 18, 2016, Petitioner saw Dr. Jordania for the last time; the record reflects the doctor advised Petitioner that she would be moving from the area. Dr. Jordania reiterated that Petitioner remained at maximum medical improvement with her present medication regimen, and discussed transitioning her care to another psychiatrist. Pet.'s Ex. 6.

The last medical visit in the record is the September 20, 2016 follow-up at Marianjoy. Petitioner reported she started taking Amantadine as directed at the last visit and was much less tired during the day. She further advised headaches on the right side of her head had returned, her blood pressure was slowly climbing, and she was still looking for a psychiatrist to replace Dr. Jordania. Petitioner reported that she was doing well in her classes and was taking more counseling classes. The diagnoses on that date included post-concussion syndrome; major depressive disorder, single episode, unspecified; posttraumatic stress disorder; posttraumatic headache, unspecified, not intractable; insomnia, unspecified; and other symptoms and signs involving cognitive functions. Dr. Sayyad's nurse practitioner provided names of potential psychiatrists, adjusted Petitioner's Ritalin dose, encouraged Petitioner to continue taking classes, and directed Petitioner to remain off work. Pet.'s Ex. 4, Pet.'s Ex. 8.

At trial, Petitioner described what she experienced from April 2013 to 2018. Petitioner testified her vision and hearing were getting worse, balance was a problem, lights and noises would cause ringing in her ears, and she became dizzy if she moved too fast. T. 27. There was a period where she could not drive because she had diminished peripheral vision and depth perception in her left eye. T. 27-28. Prior to her initial work accident, Petitioner exercised on a regular basis, did not take medication for any reason, and could sleep, go running, use the stethoscope properly, and see properly. T. 29.

Petitioner testified she returned to school at College of DuPage in 2017 and completed an Associate Degree in Applied Science in Human Services for Addictions Counseling in May 2019. T. 31-32. Petitioner described her time in college as difficult: "I had some roadblocks to try to complete it. I had a lot of help with my professors and counselors and advisors at COD to help me through. Marianjoy had given me an order for accommodations while I was in school." T. 32. Petitioner explained her accommodations included extra testing time, extra time for work, and a private area to feel safe studying. T. 32. Petitioner had trouble "flipping numbers around" and problems comprehending what she was reading. T. 33.

Petitioner described her current difficulties. She has problems sleeping and has nightmares about "these issues occasionally." T. 36. She gets dizzy and can lose her balance if she stands too quickly from a seated position. T. 36. She experiences loud ringing in her ears when she gets anxious, which causes her to get "light-headed." T. 36. She is sensitive to bright lights and she gets nervous around a lot of people "in newer situations." T. 36. She becomes anxious in public. T. 37. She uses landmarks to remember where she parked her car because she has difficulty remembering things when she gets nervous. T. 38. Petitioner takes multiple prescription medications: Lamictal for migraines, Lexapro for depression, Buspar for anxiety, Ritalin for concentration, and potassium to counteract cardiac side effects of her other medications. T. 35.

Depositions

The March 1, 2017 evidence deposition of Dr. Anjum Sayyad was admitted as Petitioner's Exhibit 10. Dr. Sayyad is board-certified in brain injury medicine as well as physical medicine and rehabilitation. Pet.'s Ex. 10, p. 5-6. Dr. Sayyad is the residency director of the physical medicine and rehabilitation medical residency program at Marianjoy Rehabilitation Hospital and is a former medical director of Marianjoy's inpatient and day rehabilitation brain injury program. Pet.'s Ex. 10, Dep. Ex. 1.

Dr. Sayyad testified she assumed Petitioner's care when Dr. Mehta left the practice; Dr. Sayyad reviewed Dr. Mehta's treatment notes prior to seeing Petitioner. Pet.'s. Ex. 10, p. 10. Dr. Sayyad first evaluated Petitioner on January 30, 2014; this was in connection with Dr. Sayyad's role as medical director of Marianjoy's Brain Injury Program. Pet.'s. Ex. 10, p. 9. At that initial evaluation, Petitioner complained of problems with concentration, headaches, and problems with sleep. Pet.'s. Ex. 10, p. 10-11. Petitioner reported Dr. Jordania was managing her medication, and her current Ritalin regimen helped her attention and concentration difficulties. Pet.'s. Ex. 10, p. 11. Petitioner further advised she was taking online classes and was also undergoing vocational rehabilitation counseling with a goal of returning to work when she was better able to perform on the cognitive tests; Dr. Sayyad explained Petitioner "was very sensitive to light and sound and was hyper-vigilant, which would be consistent with her diagnosis of PTSD." Pet.'s. Ex. 10, p. 12. Dr. Sayyad performed a physical examination and observed findings of anxiety and depression as well as a flat affect. Pet.'s. Ex. 10, p. 13. Dr. Sayyad authorized Petitioner off work and recommended she follow up with Dr. Jordania for medication management of her post-concussion neurocognitive issues with attention and concentration. Pet.'s. Ex. 10, p. 14-15.

Dr. Sayyad continued to see Petitioner every three to four months until September 2016. Pet.'s. Ex. 10, p. 17. Dr. Sayyad summarized Petitioner's treatment over that period:

> But in short, she continued to have significant amounts of anxiety, where she for a few visits continued to exhibit picking at her scalp, having problems with attention and concentration. We would occasionally make changes in some of those medications, but her anxiety was such that sometimes she could not incorporate the changes we'd recommend. One example was we had recommended trialing Inderal, which can be very helpful for headache pain and for anxiety, but she was so concerned about blood pressure changes, she couldn't really make herself take the medicine or fill the prescription. It would take a couple of visits to kind of convince her to follow through on some of the treatment because of her anxiety being so great. By the time I saw her in her last visit, September 20th of 2016, she started to show some signs of some improvement. She was taking new medicines at that point to help with her attention and focus. She continued to have headaches. They would wax and wane throughout these visits. She still had one by the last visit. She was tolerating the Ritalin. And she was, at one point, as you recall, she was seeing Dr. Jordania, but Dr. Jordania had moved to Florida so she didn't have a psychiatrist to follow-up with and was trying to identify one at that point. And she was doing a little bit better in her classes by the last visit that I saw her. Pet.'s. Ex. 10, p. 17-19.

Directed to the September 20, 2016 visit, Dr. Sayyad testified that the progress note indicated Petitioner had a much brighter affect, was smiling and appeared more optimistic on examination. Pet.'s. Ex. 10, p. 19. The assessment was post-concussion syndrome, major depressive disorder, post-traumatic stress disorder, post-traumatic headache, insomnia, and signs and symptoms involving cognitive function. Pet.'s. Ex. 10, p. 20. The treatment plan was for Petitioner to find a new psychiatrist as soon as possible, increase her Ritalin dose to combat her headaches, and Petitioner was also encouraged to continue with school. Pet.'s. Ex. 10, p. 20-21. Dr. Sayyad opined Petitioner was not yet ready to return to work as of September 20, 2016 because she had not stabilized: Petitioner was doing better in some areas, but she still had headache symptoms and her medications were being adjusted. Pet.'s. Ex. 10, p. 26-27. Dr. Sayyad clarified that her nurse practitioner, Sylvia Duraski, APN, saw Petitioner on September 20, 2016, and Dr. Sayyad thereafter discussed the case with her and signed off on the chart note. Pet.'s. Ex. 10, p. 22.

Dr. Sayyad testified that Dr. Mehta had diagnosed Petitioner with post-concussion syndrome, PTSD, neurocognitive deficits associated with the PTSD and post-concussion syndrome, and post-traumatic headache. Pet.'s. Ex. 10, p. 24. Dr. Sayyad agreed with that diagnosis and she had carried it forward as she treated Petitioner over the next three years. Pet.'s. Ex. 10, p. 24. Turning to causation, Dr. Sayyad concluded "there is a connection between Ms. Wellman being punched in the head by a student and these diagnoses." Pet.'s. Ex. 10, p. 25.

On cross-examination, Dr. Sayyad agreed she ordered neuropsychological testing on January 6, 2015; the doctor explained she ordered the testing so "we could track what her - - objectively what the difficulties she was having with her attention and concentration issue that she was reporting difficulty. It also helps us determine a baseline from which we can compare either future or past results with." Pet.'s. Ex. 10, p. 30. Dr. Sayyad confirmed the testing would also identify areas of weakness and assess whether Petitioner was ready to return to work. Pet.'s. Ex. 10, p. 30. Dr. Sayyad testified that January 6, 2015 was the last time she saw Petitioner; the remaining visits were conducted by her nurse practitioner and discussed with the doctor afterwards. Pet.'s. Ex. 10, p. 33. Dr. Sayyad did not have a record of the testing being completed and she had not reviewed any neuropsychological testing results. Pet.'s. Ex. 10, p. 29. Dr. Sayyad agreed that absent this testing there is no objective basis for work restrictions. Pet.'s. Ex. 10, p. 33.

The March 9, 2017 evidence deposition of Dr. Nancy Landre was admitted as Respondent's Exhibit 2. Dr. Landre is a board-certified clinical psychologist with specialty training in neuropsychology. Resp.'s Ex. 2, p. 5. Dr. Landre sees a variety of patients for dementia, learning disabilities, ADHD, head injuries, and other neurological disorders such as stroke and MS. Resp.'s Ex. 2, p. 5. She does both treatment and legal evaluation. Resp.'s Ex. 2, p. 5. Dr. Landre was formerly the clinical neuropsychologist for the traumatic brain injury program at Lutheran General Hospital. Resp.'s Ex. 2, p. 6.

At Respondent's request, Dr. Landre performed a neurological evaluation of Petitioner on August 19, 2013. Resp.'s Ex. 2, p. 8. The doctor explained her evaluation process:

> …I receive the records ahead of time, and I would glance at those and just get an overview of what's going on with the case. And then the patient would come in. I would meet with them first for a clinical interview that normally lasts between an

> hour to an hour and a half, during which time I would get information about their injury, their medical history, their academic history, their work history, current lifestyle, things of that nature. And then I would decide what tests I would like to have the patient be administered as part of the evaluation. So I would indicate that and give the test battery to my technician. And my technician would then take over at that point and do all of the testing with the patient. Then they score everything out, they give it back to me. I look over the test results and I would write a report and interpret them and then write a report based on my interpretation. Resp.'s Ex. 2, p. 9-10.

The battery of testing that Petitioner underwent takes between four and five hours depending on how quickly the patient works. Resp.'s Ex. 2, p. 10.

Directed to her August 19, 2013 report, Dr. Landre testified she took a history from Petitioner and reviewed outside records, and the history within the report is a combination of the two. Resp.'s Ex. 2, p. 10-11. Dr. Landre testified consistent with her report.

Dr. Landre testified the testing Petitioner underwent includes performance validity and symptom validity measures designed to ensure the patient is giving his/her best effort and to identify over-reporting of symptoms. Resp.'s Ex. 2, p. 22-24. Dr. Landre testified Petitioner failed "a bunch of those," which tells the clinician that "the patient profile is likely very exaggerated and probably is portraying her as more distressed or dysfunctional from a mental health cognitive or somatic standpoint than is actually the case." Resp.'s Ex. 2, p. 24-25. Dr. Landre explained that, based on those findings, Petitioner's cognitive test results and her psychological test results were not valid for interpretation because they did not provide a reliable or valid estimate of her status. Resp.'s Ex. 2, p. 25. The doctor testified Petitioner's scores on the cognitive tests were "essentially meaningless" and the psychological tests were of "questionable validity" such that "there might be pieces of those that are reliable and valid, but you really can't know for sure because again she's over reporting symptoms in that case." Resp.'s Ex. 2, p. 25-26.

Dr. Landre opined Petitioner "satisfied the criteria for probable malingering." Resp.'s Ex. 2, p. 31-32. The doctor provided the basis of her opinion:

> The basis for that opinion is her test results including her failure of both performance and symptom validity measures. Her improbably poor findings on the standards [*sic*] neuropsychological indices and inconsistencies between herself [*sic*] reported the symptoms and what we know about the natural course of recovery from concussion as well as other inconsistencies between her self report and information available from other sources. Resp.'s Ex. 2, p. 32.

Dr. Landre further opined Petitioner's test results suggested probable symptom magnification. Resp.'s Ex. 2, p. 33. Asked what Petitioner's neuropsychological level of functioning was as of August 19, 2013, Dr. Landre responded as follows:

> Because of insufficient effort and probable symptom exaggeration, I was unable to provide a valid estimate of her true cognitive or emotional status. But based upon

> the fact that she was driving without restrictions and attending college and obtaining passing grades following both of these injuries, my best estimate was that her true functional status was within normal limits. Resp.'s Ex. 2, p. 33.

Dr. Landre did not believe Petitioner required additional treatment, stating Petitioner had already received more treatment than would be anticipated and she had failed to respond as expected; the doctor further noted Petitioner's test results indicated her complaints were driven by factors unrelated to her injury, such as secondary gain, work avoidance, or financial compensation. Resp.'s Ex. 2, p. 34.

Turning to causal connection, Dr. Landre opined Petitioner's complaints as of August 19, 2013 were not causally related to the two work injuries. Resp.'s Ex. 2, p. 35. The doctor explained her opinion was based on published literature on the natural course of recovery from concussion as well as her test results, experience, and training. Resp.'s Ex. 2, p. 35. Dr. Landre further opined Petitioner was able to return to work full duty without restrictions and should have been symptom-free three months post-injury. Resp.'s Ex. 2, p. 35-36.

On cross-examination, Dr. Landre testified it was "not entirely clear" that Petitioner sustained a head injury. Resp.'s Ex. 2, p. 36. Dr. Landre testified there could have been a head injury the first time, specifically noting, "I had information that there were witnesses," but Dr. Landre stated the mechanism of injury of the second incident, *i.e.*, being pushed from behind, does not necessarily satisfy criteria for concussion. Resp.'s Ex. 2, p. 36. Dr. Landre conceded the March 19, 2013 Central DuPage Hospital records reflect that when Petitioner was evaluated in the emergency room on the date of accident, she reported being punched in the back of the head, but according to Dr. Landre, "she didn't report that initially so it almost seemed like the injury - - her characterization of the injury changed over time." Resp.'s Ex. 2, p. 37.

Dr. Landre testified the American Congress of Rehab Medicine defines concussion as involving either direct injury to the head or an acceleration/deceleration injury as well as some sort of alteration of consciousness at the moment of impact: "They don't have to lose consciousness, frankly. But they have to be dazed or confused or feel out of it temporarily and/or demonstrate some sort of a focal neurologic deficit." Resp.'s Ex. 2, p. 38. Dr. Landre agreed the severity of a blow to the head can be indicated by other physical damage caused by the blow, such as a ruptured eardrum. Resp.'s Ex. 2, p. 38-39. Dr. Landre testified she thought it was likely that Petitioner probably had a concussion with the first incident, but she could not say with 100 percent certainty. Resp.'s Ex. 2, p. 39.

Dr. Landre agreed she asked Petitioner to describe her current complaints prior to giving her the checklist for post-concussive syndrome symptoms, and Petitioner reported nervousness, dizziness, memory difficulties, headaches, stomach aches, sensitivity to the sun and noise, disturbed sleep, vision problems, and depression. Resp.'s Ex. 2, p. 44-46. Dr. Landre confirmed that anxiety, depression, difficulty concentrating, irritability, and fatigue are symptoms associated with both PTSD and post-concussion syndrome. Resp.'s Ex. 2, p. 49-50.

Dr. Landre confirmed her opinion was that work avoidance was a factor in Petitioner's presentation. Resp.'s Ex. 2, p. 61. The doctor then agreed Petitioner returned to work the day after

the first incident and worked for some time thereafter. Resp.'s Ex. 2, p. 61. The doctor was unaware if the employer offered Petitioner a job after the second incident. Resp.'s Ex. 2, p. 61.

The April 10, 2017 evidence deposition of Dr. Alexander Obolsky was admitted as Respondent's Exhibit 4. Dr. Obolsky is board certified in general, addiction, and forensic psychiatry. Resp.'s Ex. 4, p. 5.

At Respondent's request, Dr. Obolsky conducted a forensic psychiatric evaluation of Petitioner. Resp.'s Ex. 4, p. 7. Dr. Obolsky explained his process:

> The forensic psychiatric evaluation sits on three major activities that the focus of each is to generate reliable clinical data. One of these activities is a review of the available records. The other activity is the forensic psychological or neuropsychological testing, and the third activity is the forensic psychiatric interview. Resp.'s Ex. 4, p. 8.

Dr. Obolsky testified psychological testing was conducted on Petitioner on April 29, 2014 and he interviewed her on May 16, 2014. Resp.'s Ex. 4, p. 14. The doctor issued his report on December 31, 2014. Resp.'s Ex. 4, p. 11. Dr. Obolsky testified consistent with his report.

Dr. Obolsky emphasized the behaviors he observed which were inconsistent with PTSD, major depression, and cognitive deficiency. The doctor noted Petitioner did not exhibit any bizarre or odd behaviors which would impair her ability to work with other people. Resp.'s Ex. 4, p. 18. The doctor further noted Petitioner provided a detailed description of the school and classroom where the injuries occurred without exhibiting any emotional distress. Resp.'s Ex. 4, p. 20. Dr. Obolsky testified that Petitioner reported experiencing emotional distress, but the doctor felt Petitioner "misattributes" it to the work injuries as opposed to her pre-existing performance anxiety. Resp.'s Ex. 4, p. 21. Dr. Obolsky testified the inconsistencies indicated that Petitioner was malingering. Resp.'s Ex. 4, p. 23. Dr. Obolsky acknowledged that the diagnostic criteria for PTSD have changed so that they no longer include fear for life, but nonetheless felt that was an important factor when considering the severity of the event to a particular individual. Resp.'s Ex. 4, p. 25.

Dr. Obolsky testified the neurocognitive testing by Dr. Devereux and Dr. Lambert [*sic*] showed that Petitioner malingered, exaggerated her cognitive complaints, and her report of complaints was untrustworthy. Resp.'s Ex. 4, p. 41. Dr. Obolsky stated Petitioner's performance on RBANS, a cognitive test of memory, concentration, attention, and executive functioning, was in the lowest .01 percentile, matching people who have severe end-stage dementia; Dr. Obolsky opined the only explanation is that Petitioner was malingering. Resp.'s Ex. 4, p. 48-49. While Dr. Devereux concluded Petitioner exhibited post-traumatic stress disorder, Dr. Obolsky stated Petitioner's test results are "incontrovertible evidence that Miss Wellman started to malinger and exaggerate her symptoms very soon after the injury." Resp.'s Ex. 4, p. 50-51.

Dr. Obolsky diagnosed Petitioner as exhibiting malingering as well as exhibiting avoidant, dependent, and compulsive personality features. Resp.'s Ex. 4, p. 67. Dr. Obolsky testified the diagnosis of PTSD was inappropriate based on the totality of the data available. Resp.'s Ex. 4, p. 69. The doctor opined Petitioner "is untrustworthy reporter of her symptoms, and she misattributes

the causation that I already testified. She misreports symptoms. She manipulates symptoms. Sometimes she feigns symptoms. And so her credibility as a historian of her own symptoms is undermined significantly because she is clearly malingering." Resp.'s Ex. 4, p. 71.

Dr. Obolsky concluded that Petitioner did not develop any condition of mental ill-being causally related to either the October 23, 2012, or March 19, 2013 work events. Resp.'s Ex. 4, p. 76. The basis of his opinion was his review of the available records, review of the psychological testing by Dr. Devereux, Dr. Landon [*sic*], and Dr. Felske, and his forensic interview with Petitioner. Resp.'s Ex. 4, p. 77. Dr. Obolsky further opined Petitioner did not require any further mental health treatment as a result of either work incident, and she was fit for full-time competitive employment and had no limitations or restrictions causally related to either work event. Resp.'s Ex. 4, p. 77-78.

On cross-examination, Dr. Obolsky confirmed he reviewed the report of Dr. Karen Levine, the neurologist who evaluated Petitioner at Respondent's request on March 7, 2013. Resp.'s Ex. 4, p. 91. As to Dr. Levine's diagnosis of mild post-concussion syndrome, Dr. Obolsky stated, "Inconsistent with the available data, Dr. Levine made that error and that diagnosis." Resp.'s Ex. 4, p. 92. Dr. Obolsky confirmed he noted in his report that Dr. Levine did not appreciate the significance of Petitioner not knowing what "country" she was in; the follow exchange occurred:

Q. Doctor, I'm actually going to refer you to Page 3 of Dr. Levine's report right after it says Neurological Examination. Didn't she say she didn't know that county she was in?
A. My error. It says county.

Q. So that would be a little less bizarre, right, that a person wouldn't know what county they were in, right, than not knowing what country they were in, right?
A. I don't think so. I think that not knowing what county you are in in Chicagoland area would be quite bizarre.

Q. Doctor, what county are you in when you're in Bensenville, Illinois?
A. I don't know where Bensenville is. Resp.'s Ex. 4, p. 92-93.

Dr. Obolsky believes Petitioner exhibited a lifelong set of personality features which interfere with her interpersonal functioning and have led to dysthymia, anxiety, worries, fears, and somatic complaints. Resp.'s Ex. 4, p. 94-95. The doctor confirmed people with somatic complaints are not lying and do experience them. Resp.'s Ex. 4, p. 96. Dr. Obolsky agreed personality features can sometimes become pathological such that the person cannot work or engage in interpersonal relationships. Resp.'s Ex. 4, p. 100-101. Dr. Obolsky testified Petitioner's personality issues are not of the severity to interfere with her going back to work at her previous occupation or any other occupation. Resp.'s Ex. 4, p. 102. Dr. Obolsky highlighted that the Marianjoy physicians diagnosed post-concussive syndrome without knowing whether Petitioner lost consciousness, and "[y]ou cannot do that." Resp.'s Ex. 4, p. 127.

III. CONCLUSION OF LAW

A. Corrections

At the outset, the Commission makes the following corrections to the Decisions of the Arbitrator ("Decisions" or "Decision"):

Corrections to the Decision in Case No. 13 WC 13675

1. The Commission corrects the accident date in the heading on page 18 of the Decision from "November 23, 2012" to "October 23, 2012" consistent with the parties' stipulations

2. The Commission corrects Petitioner's age on page 23 of the Decision from 35 years old on the date of accident to 34 years old on the date of accident consistent with the parties' stipulations.

Corrections to the Decision in Case. No. 13 WC 13676

1. The Commission corrects the date of accident under the Findings section on page 2 of the "ICArbDec" decision form, from "3/19/19" to "3/19/13" consistent with the parties' stipulations.

2. The Commission corrects the Petitioner's marital status under the Findings section on page 2 of the "ICArbDec" decision form, from "single" to "married" consistent with the parties' stipulations.

3. The Commission corrects the accrual date under the Order section on page 2 of the "ICArbDec" decision form, from "March 19, 2013 through July 15, 2015" to "March 19, 2013 through July 15, 2019."

4. The Commission corrects the date of accident in the last paragraph on page 18 of the Decision from "October 23, 2013" to "October 23, 2012."

B. Credibility

The Arbitrator found Petitioner's testimony was not credible. The Commission views Petitioner's credibility differently and finds that the reasons relied on by the Arbitrator are refuted and contextualized by the evidence.

The Commission exercises original jurisdiction and is not bound by an arbitrator's findings. *See R & D Thiel v. Illinois Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 866, 923 N.E.2d 870, 877 (1st Dist. 2010) (finding that when evaluating whether the Commission's credibility findings which are contrary to those of the arbitrator are against the manifest weight of the evidence, "resolution of the question can only rest upon the reasons given by the Commission for the variance.")

The Commission makes the following findings as to Petitioner's credibility:

1. The Arbitrator found that "Petitioner was not diagnosed with a concussion, post-concussion syndrome nor did she report any concussion related symptoms to Dr. Patel, Dr. Celmer or Dr. Hsu," and that Petitioner did not report any headache symptoms or concussion symptoms until she saw Dr. Marzo on February 13, 2013.

The Commission acknowledges that Petitioner was not diagnosed with a concussion or post-concussion syndrome by Dr. Patel, Dr. Celmer or Dr. Hsu and that she did not report any headaches to these three doctors (following the October 23, 2012 accident). However, the Commission notes that Petitioner's reports of ear pain and decreased hearing on the right side to Dr. Patel on October 23, 2012 were consistent with her testimony and history of being punched in the head by a student. Further, the Commission notes that Dr. Patel referred Petitioner to Dr. Celmer, who is an ENT physician, specifically for the diagnosis of traumatic right ear tympanic membrane perforation. The Commission also notes that Dr. Celmer referred Petitioner to Dr. Hsu, who is an ENT surgeon, specifically to discuss undergoing a tympanoplasty to the right ear. With this contextual backdrop, the Commission finds that an analysis of the totality of the evidence indicates Petitioner did indeed sustain concussions after each accident and developed post-concussion syndrome.

The Commission does not agree that Petitioner did not report any concussion related symptoms or that she did not report any concussion symptoms until she saw Dr. Marzo on February 13, 2013 as the record shows several physicians diagnosed Petitioner with concussions and post-concussion syndrome. On February 11, 2013, Dr. Sam Marzo evaluated Petitioner who reported being hit in the head with a fist multiple times during an incident at work in October 2012 and reported that she had been diagnosed with post-concussion syndrome by a neurologist. Dr. Marzo diagnosed Petitioner, *inter alia*, with post-concussion syndrome for which he recommended neurologic management. The Commission notes that it would be speculative to state that Dr. Marzo diagnosed Petitioner with post-concussion syndrome based only on her report that another physician had diagnosed her with the same, when there is no evidence or deposition testimony to support this assertion.

Similarly, on March 7, 2013, Dr. Karen Levine, who performed a section 12 neurological examination of Petitioner at Respondent's request, diagnosed Petitioner with migraines and mild post-concussion syndrome. Dr. Levine opined that Petitioner's migraines were pre-existing and were aggravated by the work injury. Furthermore, even Dr. Landre, who performed an additional section 12 neurological evaluation of Petitioner at Respondent's request, acknowledged "it's likely that [Petitioner] probably had a concussion with this first [accident]," although she could not say with 100 percent certainty. Dr. Landre explained that the American Congress of Rehab Medicine defines concussion as involving either direct injury to the head or an acceleration/deceleration injury as well as some sort of alteration of consciousness at the moment of impact: "They don't have to lose consciousness, frankly. But they have to be dazed or confused or feel out of it temporarily and/or demonstrate some sort of a focal neurologic deficit." Resp.'s Ex. 2, p. 38. Dr. Landre agreed the severity of a blow to the head can be indicated by other physical damage caused by the blow, such as a ruptured eardrum. Resp.'s Ex. 2, p. 38-39.

2. The Arbitrator found Petitioner's testimony that she hit her head on a wall and blacked out on October 23, 2012 is not consistent with the Employee's Report of Injury.

The Commission acknowledges that the Employee's Report of Injury from October 23, 2012 does not state Petitioner hit her head on a wall and blacked out. However, the Commission notes the Employee's Report of Injury states Petitioner was punched in the forehead, nose, and right temporal area/ear by a student while she was trying to calm the student. On the form, Petitioner indicated that she had pain in her right cheek, ear, right eye, and neck. The Commission finds that based on the information which is contained in the Employee's Report of Injury and the totality of the evidence, whether Petitioner hit her head against a wall and blacked out is inconsequential and does not negate the fact that Petitioner sustained a serious head injury on October 23, 2012. Petitioner credibly testified that she was punched in the face, nose, and right ear which is well documented on the Employee's Report of Injury and in various medical records. These injuries, regardless of whether she also hit her head on a wall and blacked out, were traumatic and serious – so serious that her injuries caused a traumatic right ear tympanic membrane perforation and she was later diagnosed with a concussion or post-concussion syndrome by several physicians.

3. The Arbitrator found Petitioner did not provide complete medical histories to various doctors regarding her preexisting symptoms.

The Commission finds that based on the evidence, most of the physicians who examined Petitioner had some knowledge of Petitioner's medical history and pre-existing conditions, however, because the medical records are not sufficiently detailed, it is unclear exactly how much information each physician had regarding Petitioner's medical history. The Commission first notes that Dr. Patel is Petitioner's family physician who treated Petitioner for migraines and associated facial numbness and tingling prior to the October 23, 2012 accident. Petitioner returned to Dr. Patel, who already knew of Petitioner's medical history, after the October 23, 2012 accident. Further, on March 7, 2013, Dr. Levine opined that Petitioner's work injury could have aggravated Petitioner's pre-existing migraines, indicating that Dr. Levine had some knowledge of Petitioner's pre-existing condition.

After the undisputed March 19, 2013 accident, Petitioner treated with Dr. Mehta who practiced with Marianjoy Medical Group. On April 11, 2013, Dr. Mehta acknowledged that Petitioner had a pre-existing history of mild depression and opined that it was likely exacerbated by multiple assaults/concussions. Dr. Mehta referred Petitioner to Dr. Jordania, a neuropsychiatrist who also practiced with Marianjoy to address Petitioner's depression and anxiety. On November 4, 2013, Dr. Mehta transferred Petitioner's care to Dr. Sayyad who also practiced with Marianjoy. The Commission finds the evidence demonstrates Dr. Patel, Dr. Mehta, and Dr. Levine had knowledge of Petitioner's pre-existing medical history. Further, Drs. Jordania and Sayyad both practiced at Marianjoy with Dr. Mehta and most likely had access to Petitioner's records which document pre-existing conditions. In fact, Dr. Sayyad testified that she reviewed Dr. Mehta's treatment notes when she took over Petitioner's care. The Commission finds there is no evidence indicating that Petitioner purposely withheld information about her previous medical history or pre-existing conditions.

Based on the above, the Commission finds Petitioner's testimony was credible and supports her claim of suffering concussions, post-concussion syndrome, migraines, PTSD, anxiety, and depression as a result of both undisputed work accidents where Petitioner was attacked by a student on both occasions.

C. Causal Connection

The Commission finds Petitioner proved by a preponderance of the evidence that the undisputed accidents on October 23, 2012 and March 19, 2013: (1) caused Petitioner to suffer concussions and post-concussion syndrome, which resolved by July 18, 2013; (2) aggravated Petitioner's migraines and resolved by July 18, 2013; (3) caused Petitioner to suffer PTSD, which resolved by September 20, 2016; and (4) aggravated and exacerbated Petitioner's anxiety and depression, which resolved by September 20, 2016.

It is well settled that employers take their employees as they find them; even when an employee has a pre-existing condition which makes him more vulnerable to injury, and recovery for an accidental injury will not be denied as long as it can be shown that the employment was *a* causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205 (2003). An employee need only prove that some act or phase of his employment was a causative factor of the resulting injury, and the mere fact that he might have suffered the same disease, even if not working, is immaterial. *Twice Over Clean, Inc. v. Indus. Comm'n*, 214 Ill.2d 403, 414 (2005).

Moreover, with respect to the applicability of a "chain of events" analysis to a case involving a preexisting condition, courts have found 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." *Schroeder v. Ill. Workers' Comp. Comm'n*, 2017 IL App (4th) 160192WC, ¶¶ 25-26, 79 N.E.3d 833, 839. "The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been." *Id.* The appellate court also noted that "the principle is nothing but a common-sense, factual inference. *Schroeder*, 2017 IL App (4th) ¶ 26; *see also Price v. Industrial Comm'n*, 278 Ill. App. 3d 848, 853-54, 663 N.E.2d 1057, 1060-061 (4th Dist. 1996).

The Commission finds the opinions of Dr. Marzo, Dr. Levine, Dr. Mehta, and Dr. Sayyad to be credible, persuasive, and supported by the record. Additionally, the Commission finds that based on a chain of events analysis, Petitioner proved that the conditions of concussion, post-concussion syndrome, migraines, PTSD, anxiety, and depression were either caused or aggravated by the undisputed accidents.

On February 11, 2013, Dr. Marzo examined Petitioner and diagnosed her with, *inter alia*, post-concussion syndrome and recommended Petitioner continue treating for the condition with a neurologist. On March 7, 2013, Dr. Levine, Respondent's section 12 examining physician, diagnosed Petitioner with mild post-concussion syndrome and opined that Petitioner's pre-existing migraines could have been aggravated by the work injury. After the March 19, 2013 accident, the emergency room physicians at Central DuPage Hospital diagnosed Petitioner with a "new concussion," "post concussive syndrome from a head injury a few months ago," and PTSD from

the first concussion. On April 11, 2013, Dr. Mehta diagnosed Petitioner with post-concussion syndrome, neurobehavioral deficits/neurocognitive, impaired balance, insomnia, anxiety/ depression/PTSD, and chronic post-concussion headaches. Dr. Mehta opined that Petitioner had a pre-existing history of mild depression likely exacerbated by multiple assaults/concussions. On April 22, 2013, Dr. Jordania performed an initial psychiatric evaluation and diagnosed Petitioner with post-concussive syndrome, anxiety due to post-concussive syndrome, PTSD, and insomnia due to PTSD. Petitioner continued to treat with Dr. Jordania and undergo speech therapy, occupational therapy, and day rehab. On June 13, 2013, Petitioner was discharged from speech therapy. Petitioner was discharged from occupational therapy the next day. On July 2, 2013, Dr. Mehta noted Petitioner had completed a day rehab program and transitioned to a home exercise program. Dr. Mehta noted Petitioner was steadily improving but she continued to have significant PTSD symptoms.

On July 18, 2013, Petitioner followed up with Dr. Jordania and reported significant improvement in her headaches, but her PTSD was still very symptomatic. Petitioner described having persistent fear of children and people in public places as well as fear of being attacked. Petitioner continued to treat with Dr. Mehta (until her care was transferred to Dr. Sayyad), Dr. Jordania, and counselor Cromer. On September 20, 2016, Petitioner followed up at Marianjoy with Dr. Sayyad's nurse practitioner, which is the last documented medical visit in the record and reported that she was much less tired during the day and she was doing well in her classes. However, Petitioner reported that her headaches had returned, her blood pressure was slowly climbing, and she was still looking for a psychiatrist to replace Dr. Jordania who had left Marianjoy. Dr. Sayyad's nurse diagnosed Petitioner with, *inter alia,* major depressive disorder, single episode, unspecified and posttraumatic stress disorder; provided Petitioner with names of potential psychiatrists; adjusted Petitioner's medication; and encouraged Petitioner to continue taking classes. Dr. Sayyad testified that Petitioner had started to show some signs of improvement by this date and Petitioner's headaches waxed and waned throughout her treatment. At her deposition, Dr. Sayyad testified that "there is a connection between Ms. Wellman being punched in the head by a student and these diagnoses [post-concussion syndrome, PTSD, neurocognitive deficits associated with PTSD, post-concussion syndrome, and post-traumatic headache]."

The Commission finds that Petitioner was able to work her full job duties prior to the October 23, 2012 accident, and to her credit, even managed to return to work following the October 23, 2012 attack while undergoing treatment for her right ear perforated tympanic membrane. However, after the March 19, 2013 attack, Petitioner was unable to complete her job duties and return to work. The medical records indicate that her concussion, post-concussion syndrome, and migraine conditions improved over time and seemed to resolve or plateau by July 18, 2013. However, the medical records indicate Petitioner's PTSD and associated anxiety and depression did not improve as quickly and Petitioner required substantial treatment and therapy through September 20, 2016.

Furthermore, the Commission is not persuaded by the opinions of Dr. Landre, which were based on inaccurate facts and speculation. Dr. Landre's opinion that it was not clear whether Petitioner sustained a head injury during the second accident (March 19, 2013) is contradicted by the evidence. Dr. Landre testified that Petitioner's March 19, 2013 accident consisted of "being pushed from behind," which did not satisfy the criteria for a concussion. The Commission notes

that the Central DuPage Hospital emergency room records state Petitioner was hit from behind and punched in the occiput by a student. The emergency room physicians diagnosed Petitioner with a "new concussion," post-concussion syndrome and PTSD from the first concussion. Additionally, the Employee's Report of Injury for the March 19, 2013 accident (dated March 20, 2013) states that a student pushed and hit Petitioner in the back of the head. Further, Dr. Landre testified that Petitioner "failed" several performance validity tests in the neurological evaluation and initially opined that it meant Petitioner was likely exaggerating or malingering. However, Dr. Landre later testified that the failed performance validity tests meant the test results were not valid for interpretation and were not a reliable estimate of Petitioner's status. The Commission finds that Dr. Landre's reliance on invalid and unreliable testing to form her opinion that Petitioner was malingering casts doubt on the credibility of her opinion.

Additionally, the Commission is not persuaded by Dr. Obolsky's opinions which were also based on inaccurate facts and speculation. Dr. Obolsky opined that the results of his forensic psychiatric evaluation indicated Petitioner was malingering and exaggerating her complaints. Dr. Obolsky opined that Petitioner did not exhibit any "bizarre" or "odd" behaviors that would impair her ability to work with other people but did not explain what a "bizarre" or "odd" behavior was and did not explain the scientific significance of such behaviors. Additionally, Dr. Obolsky opined that Petitioner did not develop any condition of mental ill-being causally related to either undisputed accident, which contradicts the opinions of the emergency room physicians at Central DuPage Hospital, Dr. Mehta, Dr. Sayyad, Dr. Jordania, and licensed clinical professional counselor Cromer. Finally, Dr. Obolsky inaccurately believed Petitioner had reported not knowing what "country" she was in when Dr. Levine evaluated her, when in actuality, Petitioner had reported not knowing what "county" she was in when she saw Dr. Levine.

Finally, the Commission notes that Dr. Landre and Dr. Obolsky's opinions contradict each other and undermine the credibility of both opinions. On one hand, Dr. Landre testified that in order to be diagnosed with a concussion, loss of consciousness is not required, and Petitioner probably had a concussion after the first accident. Dr. Landre also confirmed that anxiety, depression, difficulty concentrating, irritability, and fatigue are symptoms associated with both PTSD and post-concussion syndrome. On the other hand, Dr. Obolsky testified that the doctors at Marianjoy diagnosed Petitioner with post-concussion syndrome without knowing whether Petitioner lost consciousness and ""[y]ou cannot do that." Dr. Obolsky appeared to opine that loss of consciousness is required for a diagnosis of concussion or post-concussion syndrome.

D. Medical Benefits

Based on the Commission's findings and conclusions above, and with respect to both cases 13 WC 13675 (October 23, 2012 accident) and 13 WC 13676 (March 19, 2013 accident) the Commission finds Petitioner's treatment for concussion, post-concussion syndrome, and migraines was reasonable and necessary, and awards medical expenses for treatment for those conditions through July 18, 2013 pursuant to sections 8(a) and 8.2 of the Act. The Commission finds that with respect to both cases 13 WC 13675 (October 23, 2012 accident) and 13 WC 13676 (March 19, 2013 accident) Petitioner's treatment for PTSD, anxiety, and depression was reasonable and necessary, and awards medical expenses for treatment for those conditions through September 20, 2016 pursuant to sections 8(a) and 8.2 of the Act.

E. Temporary Total Disability Benefits

Based on the Commission's findings and conclusions above, and with respect to case no. 13 WC 13676 (March 19, 2013 accident) the Commission finds Petitioner is entitled to temporary total disability ("TTD") benefits from March 20, 2013 through September 20, 2016. Respondent is entitled to credit for TTD benefits already paid.

F. Permanent Disability Benefits

Our conclusion that Petitioner's concussion, post-concussion syndrome, migraine, PTSD, anxiety, and depression conditions are causally related to the undisputed work accidents, necessarily implicates an analysis of Petitioner's permanent disability with respect to these conditions. The Commission finds the injuries Petitioner sustained following each undisputed accident are not separate and distinct, but rather, Petitioner was attacked and sustained injuries to her head during both accidents and her diagnoses and treatment for the injuries sustained during both accidents overlapped considerably. Further, the Commission finds that the injuries Petitioner sustained during the second accident were amplified and more serious due to the prior injuries Petitioner sustained during the first accident and the evidence does not support delineation of the nature and extent of permanency attributable to each accident. Accordingly, the Commission finds that it can only award permanency for the second accident, case no. 13 WC 13676 (March 19, 2013 accident). *See City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 265, 947 N.E.2d 863, 869 (2011).

The Commission analyzes the §8.1b factors as follows and modifies the Arbitrator's permanency award with respect to case no. 13 WC 13676:

Section 8.1b(b)(i) – impairment rating

Neither party submitted an impairment rating. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner worked as a Health Assistant for Respondent for approximately six years. Petitioner has not returned to her employment with Respondent or any other employer since the March 19, 2013 accident. The Commission gives this factor moderate weight and finds this factor is indicative of increased permanent disability.

Section 8.1b(b)(iii) – age at the time of the injury

Petitioner was 34 years old on the date of the October 23, 2012 undisputed accident. Petitioner was 35 years old on the date of the March 19, 2013 undisputed accident. Petitioner was relatively young at the time of the accidents and has many years to attempt to adapt to her residual deficits. The Commission gives this factor moderate weight and finds this factor is indicative of increased permanent disability.

Section 8.1b(b)(iv) – future earning capacity

Petitioner did not return to her pre-accident job with Respondent and Petitioner's physicians continue to place her off work. Petitioner earned an Associate's Degree in 2019 and is taking additional classes to help her find suitable employment. Petitioner submitted into evidence a vocational assessment report dated November 11, 2013 indicating she had a vocational history of EMT certification, certified phlebotomist, CNA, certification to perform school vision and hearing screenings, licensed cosmetologist, and she had paramedic training. However, Petitioner also had vocational barriers of post-traumatic stress disorder, ruptured eardrum, hand tremors, migraine headaches, jaw problems, eye problems, depression, and anxiety. Respondent submitted into evidence a labor market survey report dated February 29, 2016, which indicated appropriate vocational goals for Petitioner included claims clerk, receptionist, collections clerk, hospital-admitting clerk, radio dispatcher, administrative clerk, customer service clerk, home attendant, and teacher's aide. The wage range for those positions within a 50-mile radius was $12.00 to $23.00 per hour. The Commission gives this factor moderate weight and finds this factor is indicative of decreased permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner testified she returned to school at the College of DuPage in 2017 and completed an Associate's Degree in Applied Science in Human Services for Addictions Counseling in May 2019. Petitioner described her time in college as difficult and she required substantial help and accommodations while she was in school. The medical records corroborate Petitioner's testimony in that they indicate Petitioner failed several classes in 2014 before she was finally able to pass her classes at the College of DuPage. Petitioner testified she has problems sleeping and has nightmares about "these issues occasionally." She gets dizzy and can lose her balance if she stands too quickly from a seated position. She experiences loud ringing in her ears when she gets anxious, which causes her to get "light-headed." Petitioner gets nervous around a lot of people "in newer situations" and she becomes anxious in public. Petitioner continues to take multiple prescription medications.

On September 20, 2016, Petitioner followed up at Marianjoy with Dr. Sayyad's nurse practitioner and reported that she was much less tired during the day and she was doing well in her classes. However, Petitioner reported that her headaches had returned, and her blood pressure was slowly climbing. Dr. Sayyad's nurse diagnosed Petitioner with major depressive disorder, single episode, unspecified; posttraumatic stress disorder, *inter alia*; adjusted Petitioner's medication; and encouraged Petitioner to continue taking classes. Dr. Sayyad testified that at the time of this visit, Petitioner had started to show some signs of improvement by this date and Petitioner's headaches waxed and waned throughout her treatment. The Commission gives this factor significant weight and finds this factor is indicative of increased permanent disability.

Based on the above, the Commission finds Petitioner sustained 27.5% loss of the person-as-a whole. All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 3, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to both case nos. 13 WC 13675 and 13 WC 13676, Respondent shall pay to Petitioner medical expenses as provided in §8(a), subject to §8.2 of the Act, for treatment for Petitioner's concussion, post-concussion syndrome, and migraines through July 18, 2013.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to both case nos. 13 WC 13675 and 13 WC 13676, Respondent shall pay to Petitioner medical expenses as provided in §8(a), subject to §8.2 of the Act, for treatment for Petitioner's PTSD, anxiety, and depression through September 20, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to case no. 13 WC 13676, Respondent shall pay to Petitioner the sum of $337.46 per week for a period of 183 weeks, representing March 20, 2013 through September 20, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to case no. 13 WC 13675, Respondent shall pay to Petitioner the sum of $319.00 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the perforated right eardrum and neck injuries sustained caused 10% loss of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to case no. 13 WC 13676, Respondent shall pay to Petitioner the sum of $319.00 per week for a period of 87.5 weeks, as provided in §8(d)2 of the Act, for the reason that the concussion, post-concussion syndrome, migraine, PTSD, anxiety, and depression conditions sustained caused 17.5% loss of the person-as-a-whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. Respondent shall be given a credit for TTD benefits paid in the amount of $6,122.63 and credit for an advance in permanent disability benefits in the amount of $8,385.14. Respondent shall also 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.

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.

August 9, 2021

/s/ *Deborah J. Baker*

/s/ *Stephen Mathis*

/s/ *Deborah L. Simpson*

DJB/mck

O: 6/9/21

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0403

WELLMAN, JACKLYN
Employee/Petitioner

Case# **13WC013676**

13WC013675

CASE: GLENWOOD ACADEMY
Employer/Respondent

On 10/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.79% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
PETER J STAVROPOULOS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JACLYN WELLMAN
Employee/Petitioner

v.

CASE: GLENWOOD ACADEMY
Employer/Respondent

Case # 13 WC 013676 consolidated with
13 WC 13675

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

FINDINGS

On **3/19/19**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**26,321.88**; the average weekly wage was $**506.19**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**6,122.63** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**8,385.14** for other benefits, for a total credit of $**14,507.77**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $319.00 /week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act, less the credit for benefits Respondent already paid. Respondent shall also pay 21 6/7 weeks of TTD for the period between 3/20/13 and 8/19/13, less the credit for benefits Respondent already paid, as set forth in the Conclusions of Law attached hereto.

Respondent shall pay to Petitioner compensation that has accrued from March 19, 2013 through July 15, 2015 and shall pay the remainder of the award, if any, in weekly payments, as set forth in the Conclusions of Law attached hereto.

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

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

Signature of Arbitrator

10/1/2019
Date

OCT 3 - 2019

Procedural History

This matter was tried on July 15, 2019. The disputed issues involve: whether the Petitioner's current condition of ill-being is causally connected to the accidental injuries sustained on March 19, 2013; whether Respondent is liable for medical bills; whether Petitioner is entitled to TTD benefits after August 19, 2013; and the nature and extend of Petitioner's injuries. The parties stipulated that Respondent paid certain medical bills totaling $14,507.77. (Arb. Ex. #1, 2)

Findings of Fact

The parties stipulate that on March 19, 2013, an employer/employee relationship existed between the parties and that Jaclyn Wellman (hereafter referred to as "Petitioner") was employed as a health assistant for CASE Glenwood Academy (hereafter referred to as "Respondent"), which was a school for children with behavior disorders and physical disabilities. (T. 10-13). Petitioner's job entailed dealing directly with the students surrounding their health issues. (T. 13).

It is also stipulated that, on March 19, 2013, Petitioner sustained compensable accidental injuries when she was struck by an eight-year-old student. (T 13-14). Petitioner testified that the student weighed between 60 and 70 pounds. (T 15-16).

Prior Medical Treatment

On April 16, 2012, Petitioner treated with Dr. Sapan Patel, of DuPage Medical Group, for migraines. At that visit, Petitioner reported her migraines were getting worse and were occurring more often and for longer durations and were higher in severity. Petitioner reported additional symptoms of blurry vision, fatigue, sensory changes, facial numbness and tingling. Petitioner also that she had been experiencing difficulties speaking and putting thoughts together. Dr. Patel also ordered and MRI and CT scans of the brain and compared them an MRI and CT scans taken on May 27, 2008. Dr. Patel found the scans to be normal. Dr. Patel diagnosed chronic migraines and her proscribed Topamax and told Petitioner to taper off Fioricet which could be contributing to her symptoms. (PX 12)

On August 23, 2010, Petitioner was seen by Dr. Patel. At that time, Petitioner was complaining of blurry vision in the left eye, numbness on the left side of her face, headaches, and tingling on the left side of her face, eye, tongue, neck and down her arm.

Petitioner reported being very fatigued and that she gets tired with even minimal activity. The records show that Petitioner was taking Xanax, Lexapro and Petitioner has a family history of migraines. (PX 12)

Petitioner's past medical history also included left ear tympanoplasty, depression, anxiety, sleep disorder, psychotropic medications dating back to 2009, celiac disease and being allergic to glutens which causes her nausea and vomiting. (RX 1 and PX 5).

Petitioner testimony regarding her health prior to the incidents.

Petitioner testified that prior to October 23, 2013, she could exercise on a regular basis, could run, did not take medication for any reason, and could see properly. (T. 29).

Petitioner's testimony regarding her work Accidents

Petitioner testified that the first incident occurred on October 23, 2012, when a student was brought down to her office after a fight. The student was seven years old, in first grade, and maybe weighed between 50-60 pounds. Petitioner testified that the student punched her in the bridge of her nose, mouth and right ear and jaw. Petitioner also testified that she flew back and hit her head on the wall and that she blacked out. Petitioner testified that when she woke up, another staff member was in the room taking the student away. Petitioner testified that she completed an incident or accident report. (T. 16). Petitioner testified that she continued to work after this incident.

Petitioner testified that, on March 19, 2013, she was struck by another student who was eight-years-old and weighed between 60-70 pounds. Petitioner testified that she was in a classroom administering medication when a student punched her in in the middle of her back, jumped on her back and started punching her in the neck and back of the head. Petitioner testified that as she tried to move she hit her head on the wall in the front of the room and blacked out. Petitioner further testified that her forehead and face hit the wall. (T. 20-22). Petitioner testified that she competed a second accident report. (T. 22).

Accident Reports

On October 23, 2012, Petitioner completed an Employee's Report of Injury. On the form, Petitioner indicted that she was punched in the forehead, nose and right temporal area or ear. Petitioner listed her pain areas as the cheek, ear, neck, and right eye. (PX 1). A co-worker who witnessed the incident, Denise Polick, completed a

statement. Ms. Polick stated that Petitioner was hit in the bridge of her nose, end of her nose, and the area of her right ear. (PX 1).

On November 16, 2012, Petitioner filed a police report with the Glendale Heights Police Department for the October 23, 2012 incident. At that time, Petitioner reported being punched once in the bridge of her nose, twice on the tip of her nose and three times in the temporal area. Petitioner also reported hearing loss and her nose was swollen. (PX 1).[1]

On March 20, 2013, Petitioner completed an Employee's Report of Injury for the March 19, 2013 incident. On that form, Petitioner indicated that she was pushed on her back, was hit her in the back of the head, and her head whipped back. Petitioner reported that her head and neck were injured. Petitioner also indicted that the location of her pain was her head, eyes, ears and neck. (PX 1).

Medical Treatment

On October 23, 2012, Petitioner treated with Dr. Patel, of DuPage Medical Group. At that visit, Petitioner reported being hit in the forehead, nose and ear. Petitioner complained of right ear pain and decreased hearing. The examination of Petitioner's head showed no contusions, ecchymosis, and Petitioner's facial bones were stable. The examination of the right ear showed a central perforation of the tympanic membrane or TM. Dr. Patel diagnosed a right ear perforation and he recommended Petitioner follow up with an ENT. (PX 12).

On October 24, 2012, Petitioner was examined by Dr. Andrew Celmer, of the Glen Ellen Clinic Department of Otolaryngology. At that visit, Petitioner complained of right ear pain and hearing loss. Petitioner reported being struck in the head and nose by a student. Dr. Celmer's records state that Petitioner had no other complaints other a sore nose. Dr. Celmer assessed a right ear tympanic membrane tear (TM) and he attempted to apply a patch but Petitioner did not tolerate the patch. Dr. Celmer recommended dry ear precautions and the TM would likely heal on its own. A follow up appointment was scheduled in six weeks. (PX 3).

[1] The Arbitrator notes that Petitioner's Report of Injury, Police Report and witness statement do not indicate that Petitioner struck her head on a wall and blacked out.

On December 5, 2012, Petitioner returned to Dr. Celmer who noted that Petitioner's symptoms remained unchanged. At this visit, Petitioner complained of right ear pain. Dr. Celmer's records state that Petitioner had no other complaints. Dr. Celmer indicated that Petitioner would likely need a tympanoplasty and he referred Petitioner to Dr. Hsu. (PX 3).

On December 14, 2012, Petitioner was seen by Dr. Gregory Doefler, DDS. Petitioner reported being struck by a client, on October 23, 2012, and she felt a pop in her ear and, after a few hours, her jaw stiffened up. Petitioner also reported a popping on her right side. Dr. Doefler ordered a CT scan of the oral and maxillofacial structures which showed no osseous or soft-tissues abnormalities. (PX 11).

On December 18, 2012, Petitioner started treating with Dr. Hsu, of the Glen Ellen Clinic. At that visit, Petitioner reported hearing loss after being struck in the right ear. Dr. Hsu recommended tympanoplasty and allograft reconstruction which was performed on January 7, 2013. The operative findings revealed a 20% perforation. (PX 13)

Petitioner returned to Dr. Hsu on January 22, 2013, February 21, 2013 and March 7, 2013. Dr. Hsu's records state that Petitioner communicated well, was comfortable and she under no apparent distress. Petitioner complained of muffled hearing. Audiological diagnostic testing was ordered for the following visit. (PX 13).

On February 13, 2013, Petitioner was examined by Dr. Sam Marzo, of Loyola Medicine, pursuant to Section 12 of the Act, for evaluation of the right ear and head. Petitioner reported being struck multiple times with fists by a student. Petitioner reported to Dr. Marzo that she was told by a neurologist that she had post-concussive syndrome, occipital neuralgia, tinnitus in both ears, and TMJ.[2] Petitioner complained of a stiff jaw.

Dr. Marzo assessed central perforation of tympanic membrane, post-concussion syndrome, conductive hearing loss, subjective tinnitus and otogenic pain. Dr. Marzo indicated that Petitioner's ear pain and tinnitus should improve over time and Petitioner should continue treating with her neurologist for post-concussive syndrome and TMJ. (PX 16).

[2] The Arbitrator notes that Petitioner did not testify that she treated with a neurologist and was diagnosed with post-concussive syndrome, occipital neuralgia, tinnitus or TMJ between October 23, 2012 and March 19, 2013. The Arbitrator also notes that Petitioner did not submit into evidence the records of Dr. Chang or any other neurologist she treated with between October 23, 2012 and March 19, 2013.

After the second incident, on March 19, 2013, Petitioner went to the emergency room at Central DuPage Hospital. At that time, Petitioner reported being pushed by a student, hit her head and was punched in the back of the head near the base of her head. Petitioner reported dizziness and nausea. The emergency room records state that Petitioner reported "*at work-shoved by a student, my head went back, then he went to punch me again and he hit me in the back of the skull, I have post-concussion from another student and have constant headaches which is worse now, I feel nauseated and dizzy.*" (PX 15). Petitioner also reported that she sustained a "significant concussion" with a ruptured tympanic membrane and post-concussive syndrome as the result of an October incident involving another and she was treating with Dr. Cheng, a neurologist. The emergency room records state that Petitioner did not suffer a loss of consciousness, no numbness, no tingling or weakness anywhere. A CT scan performed which was negative. The emergency room clinical impression was listed as no diagnosis found. (PX 15).

The emergency room records also state that patient had a new concussion with post-concussive syndrome from a head injury a few months ago and she appeared to be also suffering from PTSD from her fist concussion. Petitioner was released from the hospital, given a name of a neurologist and told to follow up with her primary care physician. (PX 15).

On April 4, 2013, Petitioner was examined by Dr Sachin Mehta of Marianjoy Medical Group. The medical records state the reason for the visit was post-concussive (10/23/2012) and PTSD (3/19/2013). At that visit, Petitioner reported an initial traumatic event in October 2012 after being punched by a student between the eyes and on the right side of her scalp. Petitioner reported suffering a ruptured tympanic membrane. Petitioner also reported being diagnosed with post-concussion syndrome and she was treating with Dr. Chang a neurologist.[3] Dr. Mehta's records show that Petitioner complained of ongoing headaches, impaired balance, insomnia, mood issues and that she returned to work. Petitioner reported that a second incident on March 19, 2013 when she was hit from behind by a student and punched in the occiput by a student. (PX 8)

[3] The Arbitrator notes that Petitioner did not testify that she treated with Dr. Cheng, a neurologist, was diagnosed with post-concussion syndrome after the October 23, 2012 accident.

At this visit, Petitioner complained of trouble with "flipping letters, numbers, directions", calculating difficulties, being more irritable and less tolerant of her kids. Petitioner also reported constant headaches and eye twitching. Petitioner reported feeling nervous, anxious, and feeling fatigued most of the day. Petitioner told Dr. Mehta that she was diagnosed with PTSD. Dr. Mehta noted in his records that Petitioner reported feeling a loss of control over her life because she was working 37 hours a week, attending classes 2-6 hours a week, her husband was not working and on disability and not helping around the house and she was the primary caregiver for her children. Dr. Mehta diagnosed post-concussion syndrome, neurobehavioral deficits/neurocognitive, impaired balance, insomnia, anxiety/depression/PTSD, chronic post-concussion headaches. (PX 8)

On April 15, 2013, Petitioner was seen in the emergency room of Glen Oaks Hospital. The records state that Petitioner was well until 12:30, in the afternoon, when she developed a right-sided headache and numbness on the left side of her tongue and left lips. Petitioner also reported numbness in her left arm and left leg. The records state that Petitioner has a history of migraines with atypical aura of "flashing light" and that she takes Topamax, 75 mg twice daily, and prophylaxis, and butalbital. (PX 14).

The emergency room show that Petitioner reported being punched in the face in October and experiencing a brief loss of consciousness. The records also show that Petitioner reported sustaining a second head injury in March. The emergency room records show that Petitioner reported headaches since October, frequent nausea, postural dizziness and difficulty with balance. The records show that Petitioner reported that she was treating for post-concussion syndrome at Marianjoy clinic. (PX 14). At the emergency room, CT a scan was taken which was normal. Petitioner was diagnosed with migraine syndrome. Petitioner was told that she could increase her Topamax to 100 mg twice daily. (PX 14).

On April 22, 2013, Petitioner was seen by Dr. Nina Jordania, MD, of the psychiatry department of Behavioral Health Services at Central DuPage Hospital. At that time, Petitioner reported a history of two consecutive concussions. Dr. Mehta refereed Petitioner to Dr. Jordania for the treatment of Petitioner's anxiety. At that visit, Petitioner reported that since the first concussion she has had constant headaches, with photo and phonophobia, arm/elbow tingling, can't focus, can't sleep, nausea, twitching,

sadness, fear, unable to drive due to poor balance, irritability, and worrying.[4] Petitioner also reported ringing in her ears like sirens in her head. (PX 5).

Dr. Jordania noted that Petitioner past medical history included mild depression, anxiety, celiaç disease and that she is allergic to glutens which cause nausea and vomiting. Dr. Jordania diagnosed Petitioner with anxiety due to post-concussion syndrome, PTSD, post-concussion syndrome and insomnia due to PTSD. (PX 5).

On June 6, 2013, returned to Dr. Hsu. At that time the audiogram was taken showed normal hearing. Petitioner reported that she was treating with a neurologist and at Marianjoy. Petitioner complained of headaches, balance problems, and ringing in both ears. Dr. Hsu released Petitioner from care. (PX 13).

On July 18, 2013, Petitioner returned to Dr. Jordinia reporting a significant reduction of headaches after switching to Dexakote from Topamax. (PX 6).

On July 31, 2013, at the recommendation of Dr. Mehta, Petitioner sought counseling services from Steve Cromer, LCPC, at Pathways Psychological Services. Mr. Cromer provided individual counseling to Petitioner until July 1, 2015. Mr. Cromer reported that Petitioner was depressed, overwhelmed, exhausted, sad and angry and he related that Petitioner's inability to work was due to fears and symptoms of PTSD. (PX 5).

On August 19, 2013, Petitioner was examined by Dr. Nancy Landre, a licensed clinical psychologist who is board certified in clinical neuropsychology, pursuant to Section 12 of the Act. At that visit, Petitioner reported being stuck by a 7-year-old in the nose and right temporal/ear area on October 23, 2012. Petitioner reported seeing her PCP and ENT (Dr. Celmer) and undergoing an audiological evaluation on March 7, 2013 which showed normal hearing sensitivity and excellent speech discrimination abilities. Petitioner also reported she later developed persistent tinnitus which, her treating doctor, opined was unrelated to her hear injury. Petitioner further reported that after returning to work she started to experience headaches, jaw pain, fever, and dizziness. Petitioner advised Dr. Landre that she started seeing Dr. Rikert, whom she previously treated with

[4] Dr. Jordania's records do not indicate that Petitioner was treating with Dr. Patel prior to the October 2012 for migraines and that she previously experienced symptoms of headaches, blurry vision, facial numbness and tingling, sensory changes, fatigue, and episodes of being unable to talk.

for headaches. Petitioner advised Dr. Landre that she started to also experience eye twitching, nausea, sleep disturbances and other post-concussive symptoms. (RX 1).

Petitioner reported that she was symptomatic but continued to work until March 3, 2013. On that day, Petitioner reported that she was pushed from behind by a second grader. Dr. Landre noted the Employer's Report of Injury stated that Petitioner was pushed from behind causing her to stumble but she did not fall or strike her head on anything. Dr. Landre also noted that Petitioner treated at Central DuPage Hospital and those records showed that Petitioner did not report a loss of consciousness, a CT was normal, the exam was found to be unremarkable and Petitioner was discharged with no diagnoses being found. (RX 1).

Dr. Landre noted that Petitioner said that she stopped working after the second incident and that she was referred to Dr. Mehta, Marianjoy, by Dr. Cheng and another neurologist, which she sought a consultation.[5] Dr. Landre indicated that Petitioner underwent a neuropsychological evaluation with Dr. Devereux on May 1, 2013. Dr. Devereux found Petitioner's neuropsychological evaluation to be invalid because Petitioner significantly under-reporting her mental/personal problems while over-reporting somatic and cognitive problems. Dr. Landre noted that Dr. Devereux recommended a treatment plan for PTSD, which Petitioner declined. (RX 1).

Dr. Landre noted that Petitioner's past medical history included migraines, left ear tympanoplasty, significant psychiatric history for treatment of depression, anxiety, sleep disorder with psychotropic medications dating back to 2009. (RX 1).

Dr. Landre noted that Petitioner failed several stand-alone and embedded validity measures. Dr. Landre stated that Petitioner showed significant elevated scores on self-reported measures intended to identify malingering and that Petitioner's scores showed marked symptom over-reporting. Dr. Landre opined that Petitioner's cognitive tests were not invalid for interpretation because they portray her much more impaired than she is. Dr. Landre also opined that Petitioner's self-reporting injury related symptomatology was not credible. Dr. Landre noted that Petitioner's performance on standard cognitive tests

[5] Petitioner did not submit into evidence the records of Dr. Cheng or the other neurologist which she sought a consultation.

results were improbably low, at a level typically seen in patients with severe brain injuries or advanced dementia. (RX 1).

Dr. Landre opined that Petitioner's cognitive tests results and responses to self-reporting measures reflect probable symptom magnification.. Dr. Landre further opined that Petitioner does not need further treatment and that any complaints she has would be driven by factors unrelated to her injuries. Dr. Landre opined that Petitioner's complaints were not causally related to her work injuries but are being maintained by other factors such as work avoidance or possible financial renumeration. Dr. Landre also opined that Petitioner could return to work full duty without restrictions. (RX 1).

On August 27, 2014, Petitioner returned to Dr. Jordaia who indicated that Petitioner scored 30/30 on a MMSE. Dr. Jordania's records state that the test was not useful, in Petitioner's case, to detect cognitive defect. Petitioner continued to treat with Dr. Jordania until May 11, 2016. (PX 6).

Petitioner returned to Marianjoy on September 20, 2016 and was seen by Dr. Sayyad's nurse practitioner, Sylvia Duraski. Petitioner reported a return of headaches. The medical records state that Petitioner was alert, oriented, appeared to be smiling more and was more optimistic. Petitioner was given the names of potential psychiatrists to follow up since Dr. Jordania left the area. Petitioner was encouraged to continue taking classes she enjoys so she will be more successful. Petitioner was advised to return in six months or sooner should a problem arise. Petitioner did not return for additional treatment. (PX 4).

On December 31, 2014, Dr. Obolsky performed a Forensic Psychiatric Examination, pursuant to Section 12 of the Act. The forensic psychiatric evaluation was performed to assess Petitioner's reported mental health as a consequence of the Petitioner's work accident. The forensic psychiatric evaluation consisted of over 36 hours of record review, forensic psychiatric interview, forensic psychological and cognitive testing and data analysis. (RX 3).

Dr Obolsky opined that Petitioner's complaints of subjective trauma-related mental, emotional, and cognitive symptoms were not reliable. In his report, Dr. Obolsky stated that the objective evidence does not support Petitioner's reported subjective complaints. Dr. Obolsky opined that Petitioner was malingering (i.e. symptom

exaggeration for secondary gain) and that she suffers from avoidant dependent and compulsive personality features not causally related to her work accidents. (RX 3).

In his report, Dr. Obolsky opined there was no objective evidence that Petitioner's work accidents caused any clinically significant mental, emotional or cognitive dysfunctions. Dr. Obolsky noted that Petitioner endorsed over 40 current assorted symptoms involving various bodily systems on medical psychiatric questionnaires. Dr. Obolsky stated that on the forensic psychological testing, Petitioner exaggerated somatic and cognitive complaints consistent with malingered neurocognitive dysfunction and she also inconsistently magnified her psychiatric symptoms.

Dr. Obolsky stated that that Petitioner's reported posttraumatic symptoms during the forensic psychiatric interview but her description of some of the pathognomonic posttraumatic stress disorder symptoms were phenomenologically inauthentic. Dr. Obolsky noted that Petitioner's performance on forensic psychological testing was erratic. Dr. Obolsky stated that Petitioner made deliberate and unsophisticated attempts to represent herself in an unrealistically virtuous way on the MMPI-2 test. (RX 3).

Dr. Obolsky determined that Petitioner made non-credible over report of psychiatric, cognitive and physical symptoms. In the report, Dr. Obolsky noted that five months after Petitioner's second work injury, Dr. Landre noted that Petitioner failed symptoms validity testing and she displayed abnormal performance on multiple neurocognitive tests. Dr. Obolsky further noted that Dr. Landre assessed malingering after Petitioner's neurocognitive and psychological tests results were found invalid because of multiple failed symptoms validity indicators and evidence of over reporting on self-reporting measures. (RX 3).

Dr. Obolsky opined that the results of two neuropsychological evaluations don't offer objective evidence of mental, emotional or cognitive symptoms of post-concussion syndrome. Dr. Obolsky further opined that Petitioner did not develop post-traumatic stress disorder due to her work accidents and Petitioner could return to work full duty. (RX 3).

Surveillance

Beginning April 24, 2013 and ending through May 7, 2017, on six separate dates, Respondent conducted surveillance of Petitioner. During the surveillance, Petitioner was

observed opening her front door, carrying a garden hose and two rakes, putting items into a trash container, carrying a bag of trash, shipping at a store and pushing a shopping cart, getting mail and carrying empty bags and sitting and walking in a playground. (RX 6).

Evidence Depositions

Dr. Sayyad/Treating physician

Dr. Sayyad testified by evidence deposition on March 1, 2017. (PX 10). Dr. Sayyad testified that she did not see the Petitioner until January 30, 2014 because she previously treated with her partner, Dr. Mehta. (PX 10).

Dr. Sayyad testified that Petitioner complained of light and sound sensitively, lightheaded, and had problems with attention, memory, concentration, dizziness. Dr. Sayyad testified that Petitioner reported to the nurse that she also had ringing in both ears, vision concerns, blurred vision in the left eye and headaches. Dr. Sayyad testified that Petitioner said her symptoms were the result of post-concussion syndrome and PTSD as a result of being punched in the head in October of 2012. (PX 10).

Dr. Sayyad testified that she last saw Petitioner on September 20, 2016 and, at that time, Petitioner had a much brighter affect, was smiling and appeared more optimistic and her speech was fluent. Dr. Sayyad testified that his partner had diagnosed Petitioner with post-concussion syndrome, PTSD, neurocognitive deficits associated with PTSD, post-concussion syndrome and post-traumatic headaches. Dr. Sayyad opined there was a connection between the Petitioner being punched in the head and her diagnoses. Dr. Sayyad testified that her opinion was based upon her medical judgment and that you need a pretty significant trauma to the head to have a diagnoses of post-concussion syndrome and the associated symptoms. (PX 10).

Dr. Sayyad also opined that, as of September 20, 2016, Petitioner was unable to work because her headaches had not completely resolved and because her condition was not stabilized since Petitioner was still looking for a new psychiatrist. (PX 10).

On cross-examination, Dr. Sayyad testified that she had not reviewed any of Petitioner's neuropsychological testing. Dr. Sayyad acknowledged ordering neuropsychological testing, on January 6, 2015, which was not completed in more than two years. (PX 10).

Dr. Sayyad testified that she only reviewed the medical records from Marianjoy and she was not aware that Petitioner suffered form headaches in 2007. Dr. Sayyad further testified that she could not give an opinion as to Petitioner's current condition because she had not examined Petitioned in over two years. (PX 10).

Dr. Nancy Landre/Section 12 Examiner

Dr. Nancy Landre was deposed on March 9, 2017. Dr. Landre is a clinical psychologist specialty trained in neuropsychology. Dr. Landre testified that she sees patients in the areas of dementia, learning disabilities, ADHD, head injuries and other neurological disorders. Dr. Landre testified that she was the clinical neuropsychologist that consulted with the level one trauma center at Lutheran General Hospital in the traumatic brain injury program. (RX 2)

Dr. Landre testified that Petitioner's past medical history was significant for migraines, which Petitioner attributed to fluorescent lights in her work place, left ear tympanoplasty, depression, anxiety, sleep disorder, and celiac disease. Petitioner's depression and sleep disorders dated back to 2009. (RX 2)

Dr. Landre testified that Petitioner reported being struck by a 7-year-old student and that she did not lose consciousness, but she did feel dizzy and saw stars. Petitioner was diagnosed with a right TM perforation and she had surgery on January 17, 2013. Dr. Landre noted that an audiogram, taken 2 months later, showed normal hearing sensitivity and excellent speed discrimination ability in the ear. Dr. Landre testified that Petitioner reported complaining of tinnitus, but her doctor opined that it was unrelated to her injury and discharged Petitioner from care. (RX 2)

Dr. Landre testified that Petitioner reported a second accident, occurring on March 19, 2013, when she was pushed from behind by a second-grade student. Petitioner reported that she briefly lost her balance, but she did not fall or strike her had on anything. Petitioner was treated at Central DuPage Hospital. Dr. Landre testified that Central DuPage Hospital records showed that Petitioner's examination was unremarkable, and a CT scan was negative. Petitioner reported being referred to Dr. Mehta, at Marianjoy, who diagnosed post-concussion syndrome and recommended the outpatient brain injury day rehab program at Marianjoy. (RX 2)

Dr. Landre testified that, on May 1, 2013, Petitioner saw Dr. Devereux who determined that Petitioner showed insufficient effort and performance during symptom validity testing. Dr. Landre testified that she also conducted neuropsychological testing and her findings, just as Dr. Devereux findings, her findings also showed problems with Petitioner's effort and credibility regarding self-report of injury related symptoms. Dr. Landre noted that Dr. Devereux recommended a highly effective treatment for PTSD which Petitioner declined. The treatment involved exposure to work. Dr. Landre testified that one of the best available treatments for PTSD is exposure to work. Dr. Landre testified that when asked about returning to work, Petitioner responded that thinking about returning to work made her feel nauseous. (RX 2)

Dr. Landre testified that one of the best measures of symptom validation tests is the MMPI (Minnesota Multiphasic Personality Inventory). Dr. Landre testified that Petitioner failed a number of the symptom validity tests which showed that Petitioner was over reporting her symptoms. (RX 2)

Dr. Landre testified that Petitioner's cognitive test and psychological tests results were found not to be valid for interpretation because the tests did not provide reliable or valid estimate of what was really going in those domains. Dr. Landre testified that on some of the performance validity tests, Petitioner performed worse than patients with severe dementia in a hospital setting. (RX 2)

Dr. Landre testified that there is a predictable pattern of performance with mild head injuries, and Petitioner's patterns of deficits were not consistent with those predictable patterns. Dr. Landre testified that she would never expect to see someone with severely negative impaired spatial abilities, like Petitioner, or someone with moderately impaired fine motor skills, like Petitioner, in a case involving a mild head injury. Dr. Landre testified that she would not expect to see any effect at all on fine motor skills. (RX 2)

Dr. Landre's opined Petitioner's symptoms are related to malingering. Dr. Landre testified that she based her opinion upon the test results, Petitioner's failure on both performance and symptoms validity measures, Petitioner's poor finding on the standard neuropsychological indices and inconsistencies between self-reported and what we know about the nature and course of recovery from concussions. (RX 2)

Dr. Landre also opined that Petitioner's current condition were related to symptom magnification. Dr. Landre testified that she was unable to provide a valid estimate of Petitioner's true cognitive or emotional status based upon the testing because of Petitioner's insufficient effort during testing and symptom exaggeration. Dr. Landre opined that Petitioner's true functioning status was within normal limits based upon Petitioner attending college, passing classes, and driving without restrictions. (RX 2)

Dr. Landre opined that based upon the test results, history of reported symptoms Petitioner's complaints is being maintained by secondary gain, work avoidance or financial compensation. (RX 2)

Dr. Obolsky/Section 12 Examiner

Dr. Obolsky's evidence deposition occurred on April 10, 2017. Dr. Obolsky is board certified in general and forensic psychiatry. Dr. Obolsky testified that Petitioner did not report a loss of consciousness, mental status changes or post-traumatic amnesia when she described her work accidents which, he said, was consistent with the emergency room findings. (PX 4).

Dr. Obolsky testified that Petitioner said she reported, after the March incident, that she was experiencing dizziness, nausea, slurred speech, confusion and nonreactive pupils. Dr. Obolsky testified nonreactive pupils are present post-traumatically when you have a very sever traumatic brain injury are signs of virtual death. Dr. Obolsky testified that had a patient presented to the emergency room with nonreactive pupils and slurred speech the emergency room would have taken life saving measures and, if sucy symptoms existed, it would had been documented in the emergency room records. Dr. Obolsky noted that the emergency room records indicated that Petitioner's speech was not slurred, her pupils were equal in diameter and reactive to light, and she was not confused and was alert and oriented in all spheres. (PX 4).

Dr. Obolsky testified that Petitioner is a medical professional who has some medical education and she may know the term nonreactive pupils, but most lay people do not. Dr. Obolsky testified that the use of these terms reflects a conscious exaggeration of symptom. (PX 4).

Dr. Obolsky also testified that Petitioner reported her jaw was knocked out of place and she had jaw symptoms after the first incident. Dr. Obolsky testified that

Petitioner's jaw symptoms did not appear in any medical records until February 6, 2013, three and a half months after the October 2012 event. Dr. Obolsky testified that this shows that Petitioner is purposefully not giving a clear history of her illness suggesting symptom exaggeration. (PX 4).

Dr. Obolsky testified that, after reviewing the results from the psychological testing, Petitioner is misattributing causation. Dr. Obolsky testified that Petitioner is piling up every symptom she can think of, whether it's present or not, and she claims they are all caused by either the first or second injury. Dr. Obolsky testified that Petitioner is misattributing causation of her physical symptoms to an event for which she could receive compensation which is malingering. (PX 4).

Dr. Obolsky testified that Petitioner reported that she started to experience memory difficulties after the March 2013 incident. Dr. Obolsky noted that the first time Petitioner reported memory difficulties was during the IME, with Dr. Levine, on March 7, 2013, one week before the March incident. Dr. Obolsky testified that, at that time, Petitioner reported that she did not know what country or town she was in. Dr. Obolsky testified that one must have a very significant traumatic brain injury not to know that you are in United States or Chicago. (PX 4).

Dr. Obolsky testified that a neurologist, Dr. Cheng, performed an evaluation of Petitioner on February 7, 2013, one week before she was examined by Dr. Levine, and also performed a mental status exam which found Petitioner to be alert, oriented in all spheres and her memory, attention and concentration was normal. Dr. Obolsky testified that, based upon Dr. Cheng's examination, one month before Petitioner's second accident, her mental state was normal. Dr. Obolsky testified that this issue is significant because it shows that Petitioner did not have any cognitive symptoms after her first injury and it also shows that Petitioner started lying before the second accident. (PX 4).

Dr. Obolsky testified that the way traumatic brain injuries work is that something happens, your brain is bruised, and you, immediately, develop symptoms and, over time, the symptoms improve. Dr.Obolsky testified that the symptoms should steadily improve and resolve within 3 months of the event. (RX 4).

Dr. Obolsky further testified that after reviewing all of the physical symptoms reported and Petitioner's complaints listed in the questionnaire Petitioner endorsed over

50 separate physical complaints. Dr. Obolsky opined that both Dr. Devereux and Dr. Landre's neurocognitive testing shows that Petitioner malingered, exaggerated cognitive complaints and her subjective cognitive complaints are untrustworthy. (RX 4).

Dr. Obolsky testified that Dr. Devereux's neuropsychological testing, performed on May 1, 2013, six weeks after the second work accident, shows that Petitioner was malingering her symptom. Dr. Obolsky testified that on the RBANS test, Petitioner performed in the lowest .01 percentile and her scores were the same as people with severe end-staged dementia. Dr. Obolsky testified that the RBANS test is a cognitive test of memory, concentration, attention, and executive functioning. Dr. Obolsky opined that the MMPI-2 test showed that Petitioner was exaggerating her physical symptoms. (RX 4).

Dr. Obolsky further opined the VSVT showed that Petitioner was a malinger. Dr. Obolsky testified that a person is who is a malinger will perform well on the part of the VSVT they believe is easy and will do poorly on the part of the test they believe is hard. Dr. Obolsky testified that both parts of the test are of equal difficulty. Dr. Obolsky testified that Petitioner performed in a valid range on the perceived easy part of the test and she performed in the questionable range on the perceived hard part of the test. (RX 4).

Dr. Obolsky diagnosed malingering with avoidant dependent and compulsive personality features. Dr. Obolsky testified that his diagnoses were based upon the review of the medical records, performance of psychological testing, review of the psychological neurocognitive tests and his interview with Petitioner. (RX 4).

Dr. Obolsky opined that Petitioner did not suffer any post-traumatic disorder based upon the totality of the data which included the medical records, psychological testing, and neurocognitive testing. Dr. Obolsky testified that symptoms were missing to diagnose PTSD. Dr. Obolsky testified that Petitioner's intrusive symptoms were not authentic, her avoidance symptoms were inconsistent, and her hyperarousal symptoms were not authentic. Dr. Obolsky opined that it is inappropriate to diagnose PTSD, in this case, because Petitioner was an untrustworthy reporter of her symptoms, she misattributes the causation, misreports symptoms and she manipulates symptoms. (PX 4).

Dr. Obolsky further testified that Petitioner's credibility, as a historian of her own symptoms, is undermined significantly because she clearly malingering. Dr. Obolsky

testified that it is inappropriate to diagnose PTSD under such conditions. Dr. Obolsky noted that Petitioner refused PTSD treatment offered by Dr. Devereux and the people who diagnosed PTSD did not treat Petitioner as if she had PTSD. (RX 4).

.Dr. Obolsky also opined that Petitioner did not suffer a concussion in either work accident. Dr. Obolsky testified to be diagnose with a concussion you have to exhibit one of the four symptoms immediately after the physical force is applied to the head. Dr. Obolsky testified to be diagnosed with a concussion, you must, immediately, develop a loss of consciousness or mental state changes or post-traumatic amnesia or focal neurological signs. Dr. Obolsky testified that Petitioner did not immediately develop any of the four symptoms for both incidents. (RX 4).

Dr. Obolsky opined that Petitioner did not develop any condition of mental ill-being causally related to either the October 23, 2012 or March 19, 2013 work events. Dr. Obolsky further opined that Petitioner does not require additional medical care and she could return to work full duty, without restrictions. (RX 4).

Petitioner's Education

Petitioner testified that after the March 19, 2013 accident she started to take classes at College of DuPage. In May of 2019, Petitioner received an associate degree in applied science and human services for addiction counseling. Petitioner testified that the degree takes two years to complete. Petitioner testified that she also has an associate degree in in general studies and she is certified as an emergency medical technician, both earned prior to 2012. (T. 34).

Petitioner's Current Complaints

Petitioner testified that she still suffers sleeping problems, dizziness, when she stands up too quickly, and the tinnitus causes ringing in her ears which gets louder when she gets light-headed. Petitioner testified that she gets anxious when the ringing gets louder. Petitioner testified that she gets tingly everywhere. very dizzy and she needs to lay down. Petitioner testified that she gets nervous around a lot of people, in new situations and she needs to know whose around. Petitioner testified that she gets anxious in grocery stores and needs to find landmarks when going to the park, so she could find her car. (T. 36-38).

The Arbitrator does not find the testimony of the Petitioner to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the 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).

In support of the Arbitrator's decision related to issue (F), is Petitioner's current condition of ill-being causally connected to the accidental Injuries of March 19, 2013, the Arbitrator makes the following conclusions:

Accidental injuries need not be the sole cause of the Petitioner's current condition of ill-being as long as the accidental injuries are a causative factor resulting in the current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193 (2003). Causal connection between accidental work injuries and an injured worker's current condition of ill-being may be established by a chain of events, including Petitioner's ability to perform work duties before the date of accidental injuries and inability to perform those same duties following that date. *Darling v. Industrial Commission*, 176 Ill.App.3d 186 (1988). Petitioner's condition of health prior to the accidental injuries need not be perfect, if after an accident occurs and following the accident, the Petitioner's condition has deteriorated, and it is plainly inferable that the intervening injury caused the deterioration; the salient factor is not the precise previous condition, it is the deterioration from whatever the previous condition had been. *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC.

The Arbitrator finds, after reviewing all of the evidence, that Petitioner failed to prove by the preponderance of the evidence that she sustained a concussion, post-concussion syndrome, PTSD, TMJ, tinnitus, occipital neuralgia, anxiety, migraines that was causally related to the March 19, 2013, accident.

The Arbitrator finds the Petitioner's testimony not credible. The Arbitrator notes that Petitioner was not diagnosed with a concussion, post-concussion syndrome nor did she present concussion related symptoms to Dr. Patel, who she saw the day after the October 23, 2013 incident. When she saw Dr. Patel, in October, she only complained of ear pain and hearing loss. On October 24, 2012, when Petitioner saw Dr. Celmer, she only complained of hearing loss and a sore nose. When Petitioner returned to DR.

Celmer on October 24, 2012 and December 5, 2012, she had no other complaints. When Petitioner treated with Dr. Hsu, on December 18, 2012, January 22, 2013 and March 7, 2013, she reported no concussion related symptoms. (PX 13). The Arbitrator found that Petitioner failed to prove that she sustained a concussion or post-concussion syndrome as a result her October 23, 2012 incident. *See Jaclyn Wellman v. CASE: Glenwood Academy*, Case #13 WC 13675.

On March 19, 2013, the day of the second incident, Petitioner presented at Central DuPage Hospital and reported suffering a "significant concussion" in October and that she was diagnosed with post-concussion syndrome by Dr. Cheng, a neurologist. The Arbitrator notes that Petitioner did not submit into evidence Dr. Cheng's medical records.

Petitioner testified that she was hit by a student and that she struck her forehead on a wall and blacked out. (T. 20-22). The Central DuPage Hospital medical records do not show that Petitioner struck her forehead on the wall and blacked out. The Central DuPage Hospital medical records state that Petitioner did not suffer a loss of consciousness. (PX 15).

The Arbitrator notes that Petitioner did not state that she struck her forehead on a wall and blacked out in her Employee's Report of Injury. (PX 1). The Arbitrator finds that Petitioner's testimony conflicted with the history she provided at Central DuPage Hospital and the history she provided in her Employee's Report of Injury.

The Arbitrator also finds that Petitioner did not provide complete medical histories to various doctors regarding her preexisting conditions and symptoms she was experiencing prior to her work incidents. Petitioner attributed symptoms she was experiencing, prior to October of 2012, to have been caused by her October 23, 2012 and March 19, 2013 work incidents. Prior to October of 2012, Petitioner's migraines were getting worse and were occurring more often and for longer durations of higher severity. Petitioner was also experiencing blurry vision in the left eye, fatigue, sensory changes, facial numbness, tingling, and she was having difficulties speaking and putting thoughts together. Dr. Patel diagnosed chronic migraines and proscribed Topamax and he told Petitioner to taper off the Fioricet which could be contributing to her symptoms. In 2010, Petitioner was experiencing headaches, tingling on the left side of her face, eye, tongue, neck and down her arm. Petitioner reported being very fatigues with minimal activity.

(PX 12). Petitioner's past medical history also included left ear tympanoplasty, depression, anxiety, sleep disorder, psychotropic medications dating back to 2009, celiac disease and being allergic to glutens which causes her nausea and vomiting. (RX 1 and PX 5). When Petitioner was treated at Marianjoy she reported headaches, fatigue, nausea, eye twitching, insomnia, moodiness, and flipping letters and numbers. Petitioner did not disclose that she had been previously diagnoses with chronic migraines, celiac disease, depression, sleep disorder, anxiety and that gluten cause nausea and vomiting. When Petitioner was seen at Glen Oaks Hospital, she reported nausea, dizziness, numbness in her left arm and numbness on the left side of her tongue. While at Glen Oaks Hospital Petitioner did not report that she previously experienced symptoms of nausea, numbness in the left side of her tongue and left arm. Petitioner did not report that she had celiac disease and that glutens cause nausea and vomiting. When Petitioner treated with Dr. Jordainia she reported headaches, nausea, twitching, arm tingling and that she was unable to focus. Petitioner did not advise Dr. Jordania that she had been previously diagnosed with chronic migraines and that she previously experienced twitching, vision problems. Petitioner did not advise the doctors that she had been experiencing many of these symptoms prior to her work incidents and Petitioner also told her doctors these symptoms were caused by her work incidents. Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicated unreliability. *Gilbert. V. Martin & Bayley/Hucks*, 08 IL.W.C. 004187 (Ill. Indus. Comm'n., 2010).

Petitioner testified that, prior to the October 23, 2012 incident, she was not taking medication for any reason and that she could regularly exercise. Petitioner saw Dr. Patel on April 16, 2012, complaining that her headaches were increasing in severity, intensity and frequency. Petitioner was diagnosed with chronic migraines. Dr. Patel proscribed Topamaz and told to Petitioner to reduce the Fioricet she was taking. Petitioner also complained fatigue. Two years earlier, Petitioner reported similar symptoms which included migraines and being very fatigued even with minimal activity. The Arbitrator finds that Petitioner's testimony regarding her physical condition prior to the October 23, 2012 incident was not credible.

The Arbitrator finds the opinions of Drs. Landre and Obolsky to be persuasive. The Arbitrator does not find the opinions of Drs. Sayyad, Mehta, Jordania to be persuasive nor does the Arbitrator find the diagnoses, related to post-concussion syndrome and PTSD, found in the Central DuPage Hospital medical records, to be persuasive. The Arbitrator finds that those opinions were based upon inaccurate histories or information provided by Petitioner. It is axiomatic that the weigh accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board,* 318 Ill.App.3d 507, 514-515 (First Dist. 2000).

Petitioner advised Dr. Mehta that she was previously diagnosed with a concussion and post-concussion syndrome by Dr. Cheng, a neurologist. Petitioner did not place Dr. Chang's records into evidence. The Arbitrator notes that none of Petitioner's initial treating physicians, for the October 23, 2012 incident, diagnosed her was sustaining a concussion or post-concussion syndrome. As previously noted, the Arbitrator did not find that Petitioner suffered a concussion or post-concussion syndrome after the October 23, 2012 incident.

The Arbitrator does not find the testimony of Dr. Sayyad to be persuasive. Dr. Sayyad testified that he was not aware the Petitioner previously treated for headaches, he did not review Petitioner's neuropsychological testing and he only reviewed Petitioner's medical records from Marianjoy. The Arbitrator notes that Dr. Sayyad could not offer an opinion as to Petitioner's current condition of ill-being because he had not examined Petitioner in more than two years prior to his testimony.

The Arbitrator finds the opinions of Drs. Landre and Obolsy persuasive. The Arbitrator notes that both doctors reviewed Petitioner's medical records, examined Petitioner, reviewed neuropsychological testing. Dr. Obolsky diagnosed Petitioner as malingerer. Dr. Obolsky opined that Petitioner did not suffer PTSD. Dr. Obolsky based his opinion upon the medical records, psychological testing and neurocognitive testing. Dr. Obolsky testified that the neurocognitive testing showed that Petitioner was malingering and exaggerating her cognitive complaints. On the RBANS test, Petitioner scored in the .01 percentile similar to people who are in severe end-state dementia. The Arbitrator notes, that at the time of the testing, Petitioner was taking college classes and

receiving passing grades. Dr. Obolsky testified the MMPI-2 test showed that Petitioner was exaggerating her physical symptoms. Dr. Obolsky also opined that Petitioner did not suffer a concussion or post-concussion syndrome.

Dr. Obolsky testified that Petitioner did not have any of the four symptoms needed to properly diagnose a concussion. Dr. Obolsky testified to diagnose a concussion you must immediately exhibit one of four symptoms (i.e. loss of consciousness, mental state changes, post-traumatic amnesia or focal neurological signs). Dr. Obolsky found that Petitioner did not have any of the four symptoms immediately after the March 19, 2013 accident.

Dr. Landre opined that Petitioner's complaints were not causally related to her work injuries and were being maintained by other factors such work avoidance or financial renumeration. Dr. Landre also opined that Petitioner's performance on some of the standard cognitive test were improbably low and were at a level typically seen in patients with severe brain injuries or advanced dementia.

Dr. Landre further opined that Petitioner's complaints and course of recover, with delayed onset of many symptoms, and little or no improvement and/or worsening of alleged injury-related symptomatology were inconsistent with her injuries. Dr. Landre opined that Petitioner's cognitive tests and responses to self-reporting measures reflect probable symptom magnification. (RX 1).

Dr. Sayyad testified that when Petitioner started treating at Marianjoy she complained of blurred vision in the left eye, headaches, sensitivity to light and problems with attention and memory all the result of being punched in the head in October of 2012.

On April 16, 2012 and August 23, 2010, prior to the October 23, 2012 incident, Petitioner reported symptoms of blurry vision in the left eye, migraines increasing in frequency and duration, sensory changes, tingling down the left side of her face, difficulty talking and felt fatigued. (PX 12)

The Arbitrator notes the symptoms Petitioner's claims were related to her work injuries existed prior to her work accidents and that Petitioner failed to fully report these preexisting symptoms to her treating physicians. The Arbitrator further finds that Petitioner's actions further supports the opinions of Dr. Obolsy who testified that after reviewing the results from the psychological testing, Petitioner was misattributing

causation and Petitioner was piling up every symptom she can think of, whether it's present or not, and claim they were all caused by either the first or second injury. (PX 4).

In support of the Arbitrator's decision relating to issue, (J), has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

The Arbitrator finds that Petitioner reached maximum medical improvement at required no further medical treatment as of August 19, 2013, as of the date of Dr. Landre's independent medical evaluation. (RX 1). All medical treatment after that date is denied.

In support of the Arbitrator's decision relating to issue, (K), what amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

The Petitioner is seeking temporary total disability benefits from the date of accident through the date of hearing despite. The Arbitrator finds that Petitioner failed to prove that she was entitled to temporary total disability benefits beyond August 19, 2013.

The Arbitrator finds the most credible and persuasive evidence surrounding Petitioner's ability to return to work can be found in Dr. Landre's evaluation. (RX 1). During her testimony, Dr. Landre opined that Petitioner could return to work full duty without restrictions. Dr. Landre based her opinions, in part, upon the information provided to her and that Petitioner was driving, attending college and passing her classes. Dr. Landre testified that, "All of the valid information I had about her suggested that she should be capable of doing that type of work again." (RX 2, p. 35).

The Arbitrator finds that Dr. Landre's testimony was supported by the opinions of Dr. Obolsky, who opined that the petitioner had no psychiatric injury which would prevent her from returning to full duty work. (RX 4, p. 78).

The Arbitrator notes that Dr. Sayyad acknowledged that she never saw the results of the testing that Dr. Sayyad requested to determine whether Petitioner was able to return to work. (PX 10, p. 28-29). Absent these test results, Dr. Sayyad testified that there was no objective basis to support any restriction from work. (*Id.* at 33).

Based on all of the above, this Arbitrator awards Petitioner temporary total disability benefits from March 20, 2013, through August 19, 2013, a period of 21 6/7 weeks.

In support of the Arbitrator's decision relating to the disputed issue, (L), What is the nature and extent of the injury, the Arbitrator finds the following facts:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of Section 8.1b(b), the 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 evidence established that Petitioner was a health assistant in a school with children with behavior disorders and physical limitations. As such, it is reasonable to assume, Petitioner would continue to be at risk of being hit or struck by a child with behavior issues. Therefore, the Arbitrator find that this factor increases the amount of permanency.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, the evidence established that Petitioner was 35 years old on the date of the accident. As employees age, the body becomes less capable of recovering from injuries as someone younger than Petitioner. As such, the Arbitrator finds that this factor slightly increases the amount of Permanency.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator finds that Petitioner is capable of returning to work without restrictions but that has not for reasons unrelated to her work accident. As such, the Arbitrator finds that this factor has no impact upon the amount of permanency.

With regard to subsection (v) of Section 8.lb(b), evidence of disability corroborated by the treating medical records, Petitioner testified to symptoms unrelated to her work accident. The Arbitrator finds that Petitioner's testimony, regarding evidence of disability, was not corroborated by the treating medical records. Petitioner did make some soft-tissue complaints of pain involving her neck and nose. As such, the Arbitrator finds that this factor lessens the amount of permanency.

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, the Arbitrator finds that Petitioner suffered permanent partial disability to the extent of 7.5% loss of man as a whole pursuant to Section 8(d)(2) of the Act.

In support of the Arbitrator's decision relating to the disputed issue, (N), Is the respondent due any credit, the Arbitrator finds the following facts:

The parties stipulated that the respondent is owed a credit in the amount of $6,122.63 for temporary total disability benefits paid, and an additional $8,385.14 and

permanent partial disability advances. (Arb. Ex. 2). Respondent's credit totals $14,507.77. *Id.*

This Arbitrator has awarded the Petitioner 21-6/7 weeks of temporary total disability benefits and 7.5% loss of use of a whole person. Therefore, the Respondent shall pay Petitioner the balance of the award after deducting the sum of $14,507.77 for the credit.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC009581
Case Name	RODRIGUEZ, MARIA v. LABOR NETWORK INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0404
Number of Pages of Decision	18
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Matthew Jones
Respondent Attorney	Andrea Carlson

DATE FILED: 8/10/2021

/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

MARIA RODRIGUEZ,
Petitioner,

vs. NO: 16 WC 9581

LABOR NETWORK,
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 all issues and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with respect to 16 WC 9581 only.

This matter was consolidated with 16 WC 9582 for hearing on September 12, 2019. The Commission is only affirming and adopting the Decision of the Arbitrator with respect to case number 16 WC 9581, in that the Commission agrees Petitioner failed to prove she sustained an injury to her right leg as a result of a work accident on March 25, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 14, 2020 is hereby affirmed and adopted only with respect to 16 WC 9581.

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.

August 9, 2021

O- 6/9/21
DLS/met
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
NOTICE OF ARBITRATOR DECISION
SECTION 19K 19L 16 PENALTIES

RODRIGUEZ, MARIA
Employee/Petitioner

Case# **16WC009581**

16WC009582

LABOR NETWORK INC
Employer/Respondent

On 5/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
PETER HAVIGHORST
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
SECTION 19K, 19L, 16 PENALTIES

MARIA RODRIGUEZ
Employee/Petitioner

v.

LABOR NETWORK, INC.
Employer/Respondents

Case # 16WC009581; 16WC009582

Consolidated cases: Y

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 9/12/2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 3/25/15 and 2/15/16 Respondent **was** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,934.11;** the average weekly wage was **$442.26.**

On the date of accident, Petitioner was **52** years of age, ***unmarried***, with ***no*** dependents.

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 **$18,850.52** for TTD, $0 for TPD, $0 for maintenance, and **$0** for medical benefits.

Respondent has also paid **$2,653.50** in PPD advance, and shall be given a credit for same.

ORDER

The Arbitrator concludes that Petitioner failed to prove she sustained an injury to her right leg as a result of any work accident, which was in controversy at trial.

The Arbitrator concludes that Petitioner proved she sustained an injury to her left shoulder which arose out of and in the course of her employment. The Arbitrator further concludes that Petitioner proved she suffered an injury to her lumbar spine which arose out of and in the course of her employment. The Arbitrator denies to award any further medical care or treatment, which was in controversy at trial.

The Arbitrator finds that Petitioner sustained disability to the extent of 12% loss under 8(d)2 for her left shoulder injury (60 weeks), and 2% loss under 8(d)2 for her lumbar spine injury (10 weeks). In total, Petitioner is entitled to 70 weeks of permanent partial disability *minus* the 10-weeks of PPD previously paid by Respondent.

The Arbitrator concludes Petitioner did not prove the entitlement to any additional Temporary Total Disability benefits than those already paid through January 31, 2018, and none are awarded.

The Arbitrator finds that Respondent is only responsible for medical bills listed in Petitioner's exhibits specifically pertaining to her left shoulder and lumbar back, as limited by the medical fee schedule or negotiated rate. The Respondent is not responsible for any medical bills pertaining to injections for Petitioner's back. The Respondent is not responsible for medical bills listed in Petitioner's exhibits after the date of January 18, 2018, and as further limited by the additional findings in the written decision.

The Arbitrator additionally finds that no penalties or fees are to be awarded.

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

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

Signature of Arbitrator

May 11, 2020
Date

MAY 14 2020

ICArbDec19(b)

Maria Rodriguez,
Employee/Petitioner

Case # **16WC9581; 16WC9582**

v.

Consolidated / Watts

Labor Network, Inc.
Employer/Respondents

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties agree that on both 3/26/2015 and 2/15/2016, the Petitioner, Maria Rodriguez and the Respondents, Labor Network, Inc., were operating under the Illinois Workers' Compensation Act, and that their relationship was one of employee and employer. They also agree that Petitioner was unmarried, with no dependents at the time of the alleged accidents. Notice was not disputed.

At issue in this hearing is as follows:

(1) Whether two separate accidents occurred involving Petitioner, arising out of and in the course of her employment, involving her right knee, left shoulder and lumbar back;
(2) Whether the Petitioner's current condition of ill-being of her back is causally connected to the alleged work incident;
(3) Whether Petitioner is entitled to payment of medical bills;
(4) Whether Petitioner is entitled to Temporary Total Disability benefits;
(5) Whether it is appropriate and how much to award an amount for the nature and extent of Petitioner's injury; and
(6) Whether the imposition of any penalties or attorneys' fees is appropriate.

FINDINGS OF FACT

This matter was tried on September 12, 2019, by agreement of the parties. Petitioner was the lone witness at trial. Petitioner testified through an interpreter that she began to work for Respondent, a labor agency, in March of 2015 (Tr. P. 10). On 3/26/2015, she claimed to suffer an injury to her right knee when she slipped and fell forward. She blamed the cause of the injury on her shoes (Tr. P. 11). Petitioner did not testify with any specificity concerning the alleged accident, except that it took place. Petitioner did not state where it took place, at what time, if there were any witnesses, and she did not claim to miss any work from the incident (Tr. P. 11). She did file an Application concerning the incident which was assigned Case No. 16WC009581 by the Commission.

Petitioner further testified that on 2/15/2016, she was working for the Aryzta Bakery, having been placed in a packing position by Respondent (Tr. P. 12). In this job she was responsible for packing individual wrapped breads into boxes and also picking up material off the bakery floor Tr. P. 12). Petitioner stated that while lifting up a box filled with product, weighing approximately 40-pounds, she started to walk

and slipped, falling backwards (Tr. P. 13). She thought there was some grease or butter on the floor (Tr. P. 14). Petitioner stated she fell to the ground, and injured her left shoulder when it struck a pallet (Tr. P. 14-15). She immediately reported what had happened to her Supervisor (Tr. P. 15).

Petitioner was sent to Physician's Immediate Care ("Physicians") where she was treated for her left shoulder pain. Although some notes from Physician's mistakenly list right arm pain, Petitioner was always treated for her left shoulder (Tr. P. 18). After x-rays were completed, Petitioner was diagnosed with a contusion of her shoulder and was given extra-strength non-aspirin for pain with a release back to work without any restrictions (Ex. P. 1).

On February 22, 2016, Petitioner returned to Physicians for a follow-up visit complaining of continued pain in her shoulder (Tr. P. 20). She was released with restrictions to avoid strong gripping and repetitive motion with her left arm (Tr. P. 20). These restrictions were considered light duty, and Petitioner continued to work over the next several weeks (Tr. P. 21).

At an evaluation with Dr. Levi on March 30, 2016, the physician administered a pain injection in Petitioner's left shoulder (Tr. P. 22). Dr. Levi stated Petitioner could remain off work because of her shoulder pain, and he had her begin physical therapy at his office (Tr. P. 23). Petitioner continued to work. Her last date of work was June 6, 2016, as noted in Respondents' Wages and TTD ledger (R. Ex. 8).

On June 1, 2016, Petitioner had two separate MRI examinations, of her left shoulder and lumbar back. The exams (P. Ex. 8), concluded:

- Left shoulder: intact labrum and intact long head of biceps tendon; full thickness tear in the rotator cuff tendon; AC joint demonstrated osteoarthritic changes.
- Lumbar: normal lumbar curvature; no significant fractures or subluxations; bone marrow unremarkable; at L4-L5 a 2mm anterior disk bulge; all other disks in tact with normal soft tissue and all visible portions of the lumbar spine normal.

On October 13, 2016, Dr. Forsythe performed an independent medical examination on Petitioner (R. Ex. 1). After his review of all available medical records and an in-person assessment, Dr. Forsythe diagnosed a left shoulder rotator cuff tear, and he recommended a surgical repair (R. Ex. 1). He also recommended that the Petitioner could return to work at a 5-pound restriction for her left arm (R. Ex. 1).

On March 6, 2017, Petitioner underwent arthroscopic rotator cuff surgery for repair of her left shoulder.

On March 8, 2017, Respondent issued Petitioner a check in the amount of $5,014.66 for 17 weeks of past total temporary disability benefits, dating back to her last date of work (June 6th). Petitioner testified that after her surgery she received weekly checks from Respondent while she remained off work (Tr. P. 30).

On July 3, 2017, Petitioner began a physical therapy regimen, and by July 28th, she had completed ten sessions. At the time she reported a 75% improvement in her left shoulder, with increased use of her left arm and hand that included increased household activities.

By November 15, 2017, Petitioner was 7.5 months since her shoulder surgery, and she was recommended for a work conditioning program. Petitioner began work conditioning for 5-days per week for four weeks.

On December 29, 2017, a work conditioning progress report was issued which stated Petitioner had attended 19 sessions, the left shoulder felt better with minimal to no pain. Petitioner was able to reach overhead in all directions, and work conditioning was no longer recommended.

On January 2, 2018, the Petitioner attended a Functional Capacity Examination. During the exam, she had some complaints of left shoulder pain with repetitive activities, and she was ultimately assessed at the medium duty physical demand level.

On January 10, 2018, Petitioner returned to meet with Dr. Levi who concluded she had improved to the point she was no longer taking any pain medication. He determined she was able to return to work and lift 35 pounds, and he discharged her from any further care.

On January 31, 2018, Respondent sent a formal correspondence to Petitioner notifying her of an available position (R. Ex. 3). The correspondence noted the condition that Petitioner had to comply with the return to work policies and report to work by February 5, 2018 (R. Ex. 3).

Petitioner testified that she had received the letter (Tr. P. 36), but she did Petitioner did not report to work for the position. Petitioner further testified that she did not make contact with Respondent concerning a return to work until May 2018 (Tr. P. 37).

On May 22, 2018, Dr. Jesse Butler complete an independent medical examination regarding Petitioner's lumbar back (R. Ex. 2). After his review of the medical records, including the MRI, EMG study, FCE, and all of Petitioner's physical therapy notes, Dr. Butler concluded the Petitioner had a normal evaluation for a woman Petitioner's age (55 years old). In all, he diagnosed a resolved lumbar strain, and found:

- No objective pathology affecting her disks, and no objective findings to support ongoing complaints of pain and prolonged treatment for her back;
- No active work-related phenomenon affecting her lumbar spine, and no current causal relationship;
- Spinal injections were neither reasonable nor necessary for what Petitioner stated happened at work; and
- Petitioner had reached maximum medical improvement by 6-8 weeks after the strain, and required no treatment after June 15, 2016 related to her back.

Petitioner testified that as of the date of trial, she has not returned to work in any capacity. She submitted as part of her testimony various medical bills and treatment records pertaining to care for her lumbar back.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file.

In connection with the Arbitrator's Decision regarding Issue C, whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent; Issue F, is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator concludes as follows:

The Arbitrator notes that it is well established that a Petitioner carries the burden of proving her case by a preponderance of the evidence. "Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Parro v. Industrial Commission*, 630 N.E.2d 860 (1st Dist. 1993); *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

Among the factors to be considered in determining whether a claimant has sufficiently carried her burden is her credibility. See, *Parro*, supra. Credibility is the quality of a witness, which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony.

The Commission is not required to find for a claimant merely because there is some testimony which, if it stood alone and undisputed, might warrant such a finding. *Burgess v. Industrial Commission*, 523 N.E.2d 1029 (1st Dist. 1988). The mere existence of testimony does not require its acceptance, *U.S. Steel Corporation v. Industrial Commission*, 8 Ill. 2d 407 (1956), and the Commission is not required to accept unrebutted testimony. *Sorenson v. Industrial Commission*, 281 Ill.App.3d 373, 384 (1996). Where the sole support for an award rests on the claimant's own testimony, and claimant's actual behavior and conduct is inconsistent with that testimony, 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). Moreover, the Commission does not

To determine whether a claimant has met his requisite burden of proof by a "preponderance of credible evidence," it is necessary for the Commission to look for consistency and corroboration between a witness' testimony, conduct, and other documentary evidence to determine the truth of the matter. Where that other evidence tends to impeach or undermine a claimant's testimony, there may be sufficient cause to find that a claimant has failed to meet his requisite burden.

Petitioner's credibility overall was uneven. Her demeanor at trial seemed sincere and there were no outward signs that she was searching for words or that she was inconsistent. Rather, it is the actual testimony that does not add up with regard to the claimed knee injury but is consistent with the record and standing alone with regard to the second claimed injury to her shoulder and back. The Arbitrator also finds that Petitioner was prone to exaggeration of symptoms and post-injury limitations. Given the unevenness and exaggerations, the Arbitrator finds the medical record more persuasive when there is a contradiction.

Specifically, concerning the alleged incident of 3/26/2015, after considering the credibility of Petitioner, submitted records and evidence, the Arbitrator concludes that Petitioner did not prove that she sustained an accident that arose out of and in the course of her employment with Respondent.

Concerning the alleged incident of 2/15/2016, the Arbitrator concludes that Petitioner suffered a left rotator cuff injury and a mild lumbar strain which arose out of and in the course of her employment with Respondent. The evidence submitted at trial details the extent of the accidents which occurred. Petitioner eventually underwent approved surgery for her rotator cuff, and that injury was resolved by January 18, 2018. Petitioner suffered a mild back strain, which was resolved within six weeks after the accident (by 03/28/2016). Petitioner's sworn testimony that her lumber injury did not resolve directly contradicts the medical records, and so is unpersuasive on this point.

First, the work accident as described by Petitioner's testimony does not support an injury to her back beyond a lower back contusion. Petitioner testified that she did not land on her back, but that she hit against the pallet as she fell to the ground (Tr. P. 14). It was her left arm and shoulder that bore the brunt of her slip and fall. During the incident, she tore her rotator cuff. All subsequent x-rays and MRI's did not show support for an impairment of her back to any degree beyond a strain.

Second, during all of the initial visits for physical therapy for her shoulder, and then subsequent to her surgery, Petitioner did not seek out any therapy for her back. Petitioner only sought additional treatment when she was released from shoulder care and was confronted with returning to work.

Third, Dr. Butler credibly and conclusively determined that Petitioner had no pathology for any continued back complaints beyond six weeks after the original fall. When he met Petitioner more than two years after the original incident, he found multiple inconsistencies with her complaints compared to her clinical exams. Nowhere in her MRI or x-rays did he find support for her back complaints and he definitely concluded there were no objective findings to keep her from working at full duty.

Fourth, the submitted utilization review report and subsequent supplemental report (R. Ex. 5 & 6) conclusively found a substantial portion of the medical care was not reasonably required to cure the effects of injury to Petitioner's back. This included the non-certification of equipment [the Tens unit], numerous medications, and back injury treatment [injections].

Finally, Petitioner's testimony is suspect and unreliable. Despite all of the physician's involved in her care agreeing that she can lift 35-pounds with her left arm, Petitioner testified that she cannot hold a gallon of milk (Tr. P. 43). Far more than a legitimate doubt exists about the extent of Petitioner's injuries as she testified to at trial, and a decision cannot be based on speculation or conjecture. *See, Deere & Co. v. Industrial Commission,* 47 Ill.2d 144, 148 (1970); *First Cash Financial v. IWCC*, 367 Ill.App.3d 102, 106 (2006); *Carter v. Azaran*, 332 Ill.App.3d 948, 961, 774 N.E.2d 400 (2002). The Arbitrator takes specific notice that while Petitioner was the lone witness at trial, her testimony regarding the extent of her lumbar injury is rebutted by the plain reading of the MRI and FCE reports, the IME expert Dr. Butler, the physician-reviewed utilization reviews, and her own physician. Thus, on the extent of injury, the Arbitrator choses to rely on the medical record and the IME reports.

After considering witness' testimony at trial, submitted medical records and physician evaluations, the Arbitrator concludes that Petitioner proved a causal connection to an injury to her left shoulder and lumbar back, which both resolved. Petitioner did not prove he suffered an injury to any other body part.

In connection with the Arbitrator's Decision regarding Issue J, whether the medical services that were provided to Petitioner and related medical bills are reasonable and necessary, the Arbitrator concludes as follows:

The Arbitrator has rendered a decision, separately, finding that an accident arose out of and in the course of Petitioner's employment, and Petitioner suffered an injury to her left shoulder and her lumbar back. The Arbitrator further finds that Petitioner incurred medical fees for treatment related to her left shoulder and lumbar back and that bills related to her treatment were entered into evidence at trial.

The Arbitrator concludes that Petitioner has met her burden of proof on medical bills owed on her left shoulder. These bills are limited to those occurring before the date of January 18, 2018 when Petitioner's physician placed her at maximum medical improvement and released her from any shoulder care. There is no liability for Respondent for any bills for care after that date. The Arbitrator further finds that the bills are limited by the findings contained in Respondent's Utilization Review Reports (R. Ex. 5 & 6), which denied specific treatments and instances of coverage.

The Arbitrator concludes that Petitioner has met her burden of proof on medical bills owed on her lumbar back. These bills are limited to those occurring before the date of June 15, 2016, when the IME physician Dr. Butler determined all care for the lower back was resolved. The Arbitrator further finds that the bills are limited by the findings contained in Respondent's Utilization Review Reports (R. Ex. 5 & 6), which denied specific treatments and instances of coverage.

As such, and according to the specific limitations, the Arbitrator orders payment of the submitted medical bills, as limited by the Medical Fee Schedule.

In connection with the Arbitrator's Decision relating to Issue K, whether Petitioner is entitled to Temporary Total Disability (TTD), the Arbitrator concludes as follows:

For Petitioner to be entitled to temporary total disability benefits under the Illinois Workers' Compensation Act, she must prove she is "totally incapacitated for work by reason of the illness attending the injury." *Mt. Olive Coal Co. v. Industrial Commission*, 129 N.E. 103, 104 (Ill. 1920). Temporary total disability exists from the time an injury incapacitates an employee for work until such time as she is as far restored as the permanent character of her injury will permit. *Shell Oil Co. v. Industrial Comm'n*, 2 Ill.2d 590 (1954). To prove entitlement to any temporary total disability, Petitioner must show not only that she did not work but also that she was unable to work. *Schmidgall v. Industrial Comm'n*, 268 Ill.App.3d 845, 847 (4th Dist. 1984); *Boker v. Industrial Comm'n*, 141 Ill.App.3d 51, 55, 489 N.E.2d 913 (3d Dist. 1986).

The Arbitrator concludes that Petitioner has proven that the injury she sustained to her left shoulder and lumbar back. These required medical care and treatment which kept her off work. The Arbitrator finds that based upon the parties' stipulation, and Respondent's ledger of TTD and wages (R. Ex. 8), Petitioner was paid TTD payments from 6/6/2016, through 2/14/2018.

The Arbitrator further concludes that Petitioner was entitled to TTD from 6/6/2016 through 1/18/2018, at which time she was released from all further care for her shoulder by her physician. She had previously been placed at MMI for her lumbar injury. The Arbitrator additionally finds that Petitioner has failed to prove she was totally incapacitated for work for the time period after 1/18/2018, by reason of the illness attending the injury. Respondent is entitled to a credit for the full amount of paid TTD to Petitioner.

In connection with the Arbitrator's Decision regarding Issue L, what is the Nature and Extent of the Injury, the Arbitrator concludes as follows:

Pursuant to Section 8.1b(b) of the Act, the Arbitrator addresses Petitioner's permanent partial disability as follows:

i. Petitioner is not currently working although she was placed at MMI by Dr. Levi and Dr. Butler. Dr. Butler has also included an impairment rating of 0% for Petitioner's back injury. The Arbitrator gives these submissions medium weight.

ii. Petitioner's occupation at the time of the accident was as a packer, on the production-line of the bakery facility. On the trial date, Petitioner had been at full-duty work for her back for over two years, and placed at maximum medical improvement for her shoulder for over a year and a half. Petitioner testified that she had not attempted to return to work under Respondent's employment despite a job offer being made when she was released from care for her shoulder. Finally Petitioner testified that she had not attempted to secure a new job, or put together a job search (Tr. P. 53) since the incident. The Arbitrator gives this factor medium weight.

iii. Petitioner was 52 years of age at the time of the accident, which means she has a long work/career ahead of her. Therefore, the Arbitrator gives minimal weight to this factor.

iv. Petitioner has not proven her future earning capacity was affected by the accident. Petitioner was released to return to work, and chose not to attempt to secure a new job or put together a resume or a job search. The Arbitrator gives minimal weight to this factor.

v. Petitioner testified she still experiences discomfort in her back and sometimes in her left shoulder. Petitioner testified that she does not use any over the counter pain medications, although she did not state why not. The Arbitrator gives minimal weight to this factor.

After applying the facts of the instant case to the factors enumerated by Section 8.1b of the Act, the Arbitrator determines Petitioner has proven partial permanent disability in the amounts as follows:

- Concerning her left shoulder, 12% loss under 8(d)2 (or 60 weeks of PPD);
- Concerning her lumbar back, 2% loss under 8(d)2 (or 10 weeks of PPD); and
- Calculated in the final award, Respondent will be given credit for the previously issued check for 10 weeks of PPD [$2633.50].

In connection with the Arbitrator's Decision regarding Issue (M), whether Penalties or Fees shall be imposed upon Respondent, the Arbitrator concludes as follows:

Petitioner filed its Petitioner for Penalties and Fees pursuant to Sections 19(k), 19(L) and 16, and Respondent filed a timely response. The Arbitrator has already rendered a decision, separately, on accident and causal connection, medical bills, temporary benefits, and the nature and extent of Petitioner's injuries. Based upon the submitted medical records and testimony, the Arbitrator further concludes that Petitioner is not be entitled to penalties or fees, and none are awarded.

It is well-settled that the imposition of penalties and attorneys' fees under Section 19(k) and Section 16 is discretionary. *McMahan v. Industrial Comm'n*, 183 Ill.2d 499, 515 (1998). The standard for awarding penalties and attorney fees under Sections 19(k) and 16 is higher than the standard for awarding penalties under Section 19(L). *McMahon*, 183 Ill.2d at 515. It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause to award penalties under Sections 19(k) and 16. Both require a vexatious delay in payment. *Vulcan Materials Co. v. Industrial Comm'n,* 362 IllApp.3d 1147, 1150 (2005).

An employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act. *Matlock v. Industrial Comm'n*, 321 Ill.App.3d 167, 173 (2001). Where an employer is in possession of facts that would justify a denial of benefits, penalties and fees are generally inappropriate. *ElectroMotive Division v. Industrial Comm'n*, 250 Ill.App.3d 432, 436 (1993). Good faith must be assessed objectively, thus the question is whether an employer's denial of benefits was reasonable. *ElectroMotive*, 321 Ill.App.3d at 436. The employer bears the burden of demonstrating that its denial of benefits was reasonable. Id.

Respondent did not engage in an unreasonable and vexatious delay in payment of any benefits. Respondent had Petitioner evaluated for an IME with its physician, and relied upon its IME physician's findings before it agreed to authorize shoulder surgery. It then remitted payment for prior TTD to Petitioner. Based upon the surgery and subsequent treatment which kept Petitioner off work, Respondent continued to make weekly TTD payments. Once Petitioner was found to have completed all shoulder care, Respondent terminated any additional TTD benefits. Respondent's reliance on its expert's clinical assessment was not unreasonable, and Respondent's actions do not rise to the threshold level of callousness required for an imposition of penalties and fees under Sections 19(K), 19(l) and 16. This holds for consideration of the shoulder and the lumbar injury, as well as any medical bills.

Respondent did not engage in an unreasonable and vexatious delay in payment of any medical bills. To the contrary, Respondent made a good faith attempt to process the bills and match its responsibility for payment. To wit, Respondent raised a valid defense to any penalties or fees on medical bills on two basis: one, based upon its reliance on its expert's opinions on causation and the nature and extent of any back injuries (through IME); and two, Respondent's sought-after evaluation of medical treatment and bills via a utilization review.

Key here is the fact that Petitioner only turned over its final tally of all the medical bills on April 22, 2019. Immediately thereafter, Respondent had the billings submitted to utilization review, and received

its UR analysis within 60-days – a evaluation which took into account billings from 15 separate providers that totaled a claim for over $250,000.00.

It is well settled that Section 8.7(i) indicates that a utilization review "will be considered by the Commission, along with all other evidence and in the same manner as all evidence, in the determination of the reasonableness and necessity of the medical bills or treatment." *Hardy v. Murray Developmental Center*, 07 WC 48727, 09 I.W.C.C. 0725, 2009 WL 2516197 (July 15, 2009). The aspiration and then actual securing of a utilization review on the medical bills cannot be considered vexatious nor a delay tactic by Respondent.

Moreover, herein Respondent made a 'good-faith' offer of ten weeks of PPD to this Petitioner, in order to ensure there was no untimely or damaging wait by Petitioner for the UR analysis to be concluded.

Finally, the Arbitrator has found that Petitioner exaggerated both her symptoms and supposed physical limitations. The Arbitrator does not take the opportunity to use his discretion, in light of all the other reason discussed above, to award penalties to someone who is not completely forthright.

The Arbitrator concludes that the cumulative actions of Respondent were not unreasonable and do not prove a level of callousness required for an imposition of penalties and fees under Sections 19(K), 19(l) and 16.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC009582
Case Name	RODRIGUEZ, MARIA v. LABOR NETWORK INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0405
Number of Pages of Decision	28
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Matthew Jones
Respondent Attorney	Andrea Carlson

DATE FILED: 8/9/2021

/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

MARIA RODRIGUEZ,

Petitioner,

vs. NO: 16 WC 9582

LABOR NETWORK,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

This matter was consolidated with 16 WC 9581 for hearing on September 12, 2019. In February of 2016, Respondent, a staffing agency, sent Petitioner to work at a bakery called Aryzta where her job duties included packing bread into boxes. On February 15, 2016, Petitioner was lifting a 40-pound box of bread and walking when she slipped and fell backwards. Petitioner thought she slipped on butter, as the bakery floor always had butter on it and her foot felt as though it had slipped on something grease-like. Petitioner testified that when she fell, she hit her back against the ground and her left shoulder on a wood pallet.

The treatment records show that Petitioner presented to Physicians Immediate Care on the accident date with complaints of back pain and reported hitting her upper back on a pallet after falling backwards while carrying a bread box. After X-rays of the thoracic spine and right shoulder yielded normal results, PA Jack Enter diagnosed Petitioner with contusions of the right shoulder

and right back thorax wall. At the hearing, Petitioner clarified that it was an error where this record referenced her right arm, because it was her left arm that was the problem. PA Enter found that Petitioner remained fit for duty without restrictions and prescribed All Day Pain Relief and Non-Aspirin Extra Strength.

When Petitioner returned on February 22, 2016 with complaints of left upper extremity, neck, and back pain, PA Enter diagnosed her with a left upper arm contusion. He prescribed Mobic and implemented light duty restrictions of no prolonged bending over, prolonged twisting, or strong gripping with the left hand. Petitioner was also instructed to limit repetitive motion with her left hand. PA Enter continued to recommend light duty restrictions at follow-up appointments on February 29, 2016 and March 7, 2016. Petitioner then presented for a physical therapy evaluation on March 15, 2016. When she returned to Physicians Immediate Care on March 22, 2016, PA Enter continued Petitioner's physical therapy sessions and placed her on 10-pound lifting restrictions for both arms. Petitioner was further instructed to avoid kneeling and bending over.

Petitioner then presented to Dr. Gabriel Levi of Orthopaedic and Rehabilitation Centers on March 30, 2016. Petitioner told Dr. Levi that on February 15, 2016, she was walking with a box of bread when she tripped on another box that she did not see on the floor. Petitioner reported that she landed on a pallet and then on stairs, causing injury to her neck, left shoulder, and low back. Left shoulder X-rays revealed a normal shoulder with no fractures, and lumbar X-rays further revealed no fractures, significant arthritis, spondylolysis, or listhesis. However, cervical X-rays demonstrated some loss of lordosis. Dr. Levi diagnosed Petitioner with impingement syndrome and a left shoulder contusion, as well as cervical and lumbar sprains. He administered a left shoulder injection, recommended a TENS unit, and placed Petitioner off work. Petitioner did not return to work with Respondent or any other employer after this visit.

Petitioner was again given light duty restrictions when she returned for follow-up appointments at Physicians Immediate Care on April 5, 2016, April 19, 2016, and May 3, 2016. However, on May 11, 2016, Dr. Levi continued his off-work restrictions due to Petitioner's ongoing lumbar and left shoulder complaints. He also recommended NSAIDs, Flexeril, tramadol, topical anti-inflammatory analgesic cream, and additional physical therapy. Petitioner subsequently started another round of physical therapy on June 8, 2016 that focused on her left shoulder impingement and lumbar sprain.

On June 1, 2016, a lumbar MRI revealed a L4-L5 posterior annular broad-based disc bulge indenting the thecal sac with mild bilateral neuroforaminal narrowing and exacerbated by ligamentum flavum hypertrophy. CT and MRI arthrograms of the left shoulder taken the same day further showed a full-thickness rotator cuff tear and AC inferior hypertrophic spurring with some impingement of the supraspinatus tendon.

Upon review of these studies, Dr. Levi diagnosed Petitioner with a left shoulder rotator cuff tear and lumbar sprain on June 15, 2016. Dr. Levi recommended a left shoulder arthroscopy, lumbar injection, and continued off-work restrictions. When Petitioner returned on August 15, 2016, Dr. Levi also referred her to a pain management specialist for her lumbar spine and ordered additional physical therapy. As they continued to await surgical approval, on September 14, 2016,

Dr. Levi again kept Petitioner off work and prescribed several medications, including meloxicam, omeprazole, tramadol, and Terocin patches.

At Respondent's request, Petitioner then presented for a §12 examination for her left shoulder with Dr. Brian Forsythe on October 13, 2016. Dr. Forsythe noted that the initial medical records documented right shoulder complaints and treatment; however, Petitioner insisted that her problem was always left-sided. Dr. Forsythe opined that if it were true that Petitioner's complaints were always left-sided, he would consider her left shoulder condition to be work-related, as the mechanism of injury was of sufficient magnitude to cause her left shoulder rotator cuff tear. He found that Petitioner had not yet reached MMI and instead recommended a rotator cuff repair, subacromial decompression, and biceps tenodesis. Dr. Forsythe also recommended restrictions of no overhead lifting, no repetitive left upper extremity use, and no lifting more than five pounds.

Following the §12 examination, Petitioner returned to Dr. Levi on October 19, 2016. Dr. Levi kept Petitioner off work, continued to recommend left shoulder surgery, and referred Petitioner to pain management for her lumbar spine. Petitioner thereafter presented to Midwest Anesthesia and Pain Specialists ("MAPS") on October 27, 2016 and was diagnosed by PA Billy Hayduk with low back pain, lumbar radiculopathy, lumbar intervertebral disc displacement, left shoulder pain, a traumatic rotator cuff tear, neck pain, thoracic pain, and other arthropathies. PA Hayduk opined that Petitioner's injuries were due to the February 15, 2016 accident and not any preexisting condition. He also indicated that Petitioner's lumbar radiculopathy was documented in her physical examination and corroborated by her MRI. PA Hayduk recommended a bilateral L4-L5 transforaminal epidural steroid injection, as well as C4-C6 facet injections upon noting that Petitioner also had facet-oriented, non-radicular cervical pain.

On November 23, 2016, Dr. Levi recommended a Game Ready Cold Therapy System for Petitioner's lumbar spine. Petitioner then underwent a bilateral L4-L5 transforaminal epidural steroid injection on November 29, 2016. When she returned to MAPS on December 28, 2016, Petitioner reported 60% relief for 20 days after the injection, although the pain was returning. Given the pain relief, PA Hayduk recommended repeat lumbar injections and kept Petitioner off work. He also indicated that he would hold off on any cervical injections until after Petitioner underwent the approved left shoulder surgery, as her neck and shoulder symptoms could be related.

On January 4, 2017, Dr. Levi opined that Petitioner had plateaued regarding her low back and would benefit from pain management. When Petitioner next presented to MAPS on January 27, 2017, PA Angie Osmanski continued to recommend repeat lumbar injections along with Terocin patches. At the next visit on February 24, 2017, PA Osmanski also referred Petitioner to a spinal surgeon for her ongoing lumbar radiculopathy and continued her off-work restrictions.

On March 2, 2017, Petitioner underwent the left shoulder surgery, which included an arthroscopy with rotator cuff repair, extensive debridement and synovectomy, subacromial decompression with acromioplasty, distal clavicle excision, and debridement of the Type I SLAP. Following the surgery, Dr. Levi ordered a Continuous Passive Motion Device and Game Ready Cold Therapy System for Petitioner's left shoulder. Petitioner thereafter began postoperative physical therapy on March 7, 2017.

When Petitioner returned to MAPS on March 24, 2017, she reported that her low back pain had returned with right lower extremity radicular symptoms. PA Osmanski again recommended repeat lumbar injections and referral to a spinal surgeon for a consultation regarding her lumbar radiculopathy. On April 12, 2017, Dr. Levi then ordered a Continuous Passive Motion Device and Game Ready Cold Therapy System for Petitioner's left shoulder for another six to 13 weeks. He also kept Petitioner off work and recommended more physical therapy.

On April 21, 2017, PA Hayduk continued to recommend a lumbar injection along with patches, cream, and oral medication. When Petitioner returned to MAPS on May 19, 2017, Dr. Thomas Pontinen made the same recommendations and referred Petitioner to Dr. Salehi, a spine surgeon, for her low back pain. Petitioner then underwent the lumbar epidural steroid injection at L4-L5 on June 2, 2017; however, she reported no post-injection relief as of June 16, 2017. Shortly thereafter, on June 22, 2017, an EMG/NCS revealed mild radiculitis affecting L4 to S1 bilaterally.

On June 28, 2017, Dr. Levi indicated that Petitioner was doing well three months after her rotator cuff repair. He kept Petitioner off work, ordered a TENS unit, and prescribed topical anti-inflammatory and analgesic cream. Dr. Levi thereafter kept Petitioner off work and adjusted her prescription medications at follow-up visits on August 2, 2017, September 6, 2017, and October 11, 2017. Following the completion of her physical therapy, Petitioner then participated in work conditioning from November 14, 2017 through December 29, 2017.

While in work conditioning, Petitioner followed up with Dr. Levi on November 15, 2017. Dr. Levi reported that Petitioner's left shoulder was improving but still a little stiff. At that time, Dr. Levi recommended transitioning Petitioner to all non-narcotic medication along with topicals, a TENS unit, and therapy. He continued to maintain Petitioner's off-work restrictions.

On January 2, 2018, Petitioner presented for a functional capacity evaluation that placed her capabilities at the light-medium physical demand level, which was indicative of a two-hand occasional lift of 35 pounds from floor to chest-level. The evaluator concluded that Petitioner's demonstrated abilities showed that she could not return to her full duty work activity. On January 10, 2018, Dr. Levi agreed that Petitioner should have a 35-pound weight restriction with no over-shoulder work per the functional capacity evaluation. Dr. Levi also noted that Petitioner was doing much better post-surgery and no longer taking any pain medications. He indicated that Petitioner could follow-up as needed. However, on January 17, 2018, Dr. Levi made an addendum to this note clarifying that although Petitioner was discharged for her shoulder, her lumbar spine remained painful. He then referred Petitioner to Dr. Hong Xvan Vo, a pain management doctor.

Petitioner presented to Dr. Vo for evaluation of her back pain on January 24, 2018. Petitioner informed Dr. Vo that on February 15, 2016, she was carrying a 35 to 40-pound box of bread when she fell onto her buttock with the box falling on top of her. Petitioner indicated that the pain sometimes radiated to her right lateral upper thigh with no pain below her knee. Dr. Vo diagnosed Petitioner with sacroiliitis, lumbosacral radiculopathy, lumbar intervertebral disc displacement, and sacrococcygeal disorders. Dr. Vo kept Petitioner off work and recommended a ganglion impar block as well as a right sacroiliac joint steroid injection.

On January 31, 2018, Respondent sent Petitioner a letter indicating that it had found a position for her that fell within the restrictions Dr. Levi imposed on January 10, 2018. Respondent asked Petitioner to report to the modified duty position on February 5, 2018. Respondent further indicated that failure to accept this position or report to work could affect Petitioner's temporary disability compensation or result in a loss of her re-employment or reinstatement rights.

On February 28, 2018, Petitioner informed Dr. Vo that she wanted to proceed with the approved sacroiliac joint injection. However, Dr. Vo indicated that Petitioner should hold off on the injection for a few more weeks since she was taking antibiotics for a tooth infection. Petitioner eventually underwent the right sacroiliac joint steroid injection on April 11, 2018.

On May 16, 2018, Petitioner told Dr. Levi that the injection did not provide relief. Dr. Levi reported that although Petitioner was better with respect to her shoulder, she still had lumbar complaints and a disc bulge on MRI. Dr. Levi indicated that he did not have any further treatment he could provide for Petitioner's lumbar spine, but he recommended that Petitioner see a spine surgeon. In his treatment note, Dr. Levi took Petitioner off work, because Petitioner said she could not walk and felt pain and numbness in her back and legs. However, an accompanying work status note stated that Petitioner could perform light duty work with 10-pound lifting, carrying, pushing, and pulling restrictions.

At the hearing, Petitioner testified that when she received the note from Dr. Levi releasing her with restrictions, she took the document to the bakery but was told that she was no longer in their system or employed. Petitioner's counsel also made an offer in May of 2018 for Petitioner to return to work within Dr. Levi's restrictions. Petitioner testified that Respondent never contacted her to offer her any light duty position other than the offer that was previously made in January of 2018. Petitioner further testified that she never resigned or quit from her employment with Respondent and had never worked elsewhere since her accident.

At Respondent's request, Petitioner then presented for a §12 examination with Dr. Jesse Butler for her low back on May 22, 2018. Dr. Butler did not agree that the lumbar MRI taken on June 1, 2016 showed a disc protrusion at L4-L5. Instead, he believed that Petitioner's MRI was normal for her age and that Petitioner did not have any objective pathology affecting her lumbar discs. Dr. Butler's diagnosis was a lumbar strain only. Although Dr. Butler indicated that Petitioner's mechanism of injury caused a lumbar strain, he found no current causal relationship between the lumbar strain and the alleged accident. He opined that there were no objective findings to support Petitioner's ongoing complaints and no objective pathology from the work incident. Dr. Butler further opined that Petitioner would have reached MMI six to eight weeks after the lumbar strain by June 15, 2016. He found that Petitioner did not require any treatment subsequent to that date and further opined that the lumbar injections were neither reasonable nor necessary. Lastly, Dr. Butler opined that Petitioner could return to full duty work without restrictions for her lumbar spine. He gave Petitioner a 0% whole person impairment rating.

Respondent subsequently obtained a UR that resulted in an appealed report dated August 8, 2019 authored by Dr. Nitin Kukkar, a board certified orthopedic surgeon. Although the UR report approved some of Petitioner's treatment, it non-certified a substantially greater amount of treatment, including but not limited to, the left shoulder injection on June 1, 2016, the lumbar

injections on November 29, 2016 and June 2, 2017, the sacroiliac joint injection on April 11, 2018, the lumbar MRI, the CT arthrogram of the left shoulder, the TENS unit, the Continuous Passive Motion Device, various PT visits, and numerous medications.

At the time of the hearing, Petitioner's neck continues to hurt when she moves it to the left and backward. Due to her neck injury, Petitioner indicated that she cannot do her daily chores at home. Specifically, Petitioner testified that her neck hurts all the way to her back and hip when she goes to the laundromat, pulls out wet clothes, and folds clothes.

Regarding her low back, Petitioner also experiences ongoing pain when she is seated or laying down. Petitioner explained that she has to grab onto something to turn sideways when she is in bed and to turn around when she is laying face down. Additionally, Petitioner must hold onto something to sit down onto a toilet. Petitioner further testified that she cannot mop, bend to clean walls, or stretch upward to clean spiderwebs due to her back pain. Although Petitioner no longer takes any prescription pain medication for her back, she takes three Advil pills every night to sleep.

Regarding her left shoulder, Petitioner further testified that she felt better for a couple months post-surgery, but her arm has started hurting again. Although she can move her arm, Petitioner can no longer lift heavy objects with her left arm. For example, Petitioner testified that she cannot hold a gallon of milk with her left arm like she can with her right. Additionally, Petitioner testified that her left shoulder hurts and pulsates when the weather changes. Nevertheless, Petitioner was not taking any prescription medications at the time of the hearing aside from her diabetes medication.

Other than her alleged work injuries, Petitioner has not had any other injuries or accidents involving her neck, low back, or left shoulder. At the time of the hearing, she was not participating in any current job search.

II. CONCLUSIONS OF LAW

a. *Causal Connection*

Following a careful review of the entire record, the Commission finds that the current condition of Petitioner's lumbar spine is causally related to the February 15, 2016 accident. As opposed to a mere resolved lumbar strain, the record establishes that Petitioner sustained a L4-L5 disc protrusion with ongoing lumbar radiculopathy as a result of her work-related accident.

Petitioner's MRI and EMG/NCS present objective findings that show Petitioner's injury was more severe than a mild lumbar strain. On June 1, 2016, the lumber MRI revealed a posterior annular broad-based disc bulge at L4-L5 that indented the thecal sac with mild bilateral neuroforaminal narrowing and was exacerbated by ligamentum flavum hypertrophy. Thereafter, the EMG/NCS conducted on June 22, 2017 demonstrated a mild radiculitis affecting L4-S1 bilaterally. This EMG/NCS supports the diagnoses of lumbar radiculopathy and lumbar intervertebral disc displacement made by Petitioner's treating doctors. PA Hayduk indicated on October 27, 2016 that the lumbar radiculopathy was documented by Petitioner's physical examination as well as corroborated by her MRI. He found that Petitioner's lumbar injuries were

due to the work-related accident on February 15, 2016 and not any preexisting condition.

Dr. Butler was the only medical provider to disagree with Petitioner's lumbar MRI findings. Specifically, Dr. Butler opined that the MRI was normal for Petitioner's age and did not show any objective pathology affecting her lumbar discs. However, the Commission finds that Dr. Butler's opinion is weakened by the objective MRI findings, EMG/NCS findings, and the treating doctors' opinions that all support a finding of lumbar radiculopathy.

Moreover, contrary to the notion that Petitioner only sought treatment for her back after she was released from care for her shoulder injury, the treatment records show that Petitioner immediately complained of and sought treatment for her lumbar pain. When Petitioner first presented to Physicians Immediate Care on February 15, 2016, she promptly complained of back pain. At her second treatment visit on February 22, 2016, Petitioner again complained of ongoing back pain. Then, when she first presented for evaluation with Dr. Levi, Petitioner again complained of a low back injury. Although there was a period of treatment that focused predominantly on Petitioner's left shoulder surgery, Petitioner consistently treated for her lumbar complaints while simultaneously receiving left shoulder treatment.

Petitioner had no documented pre-accident lumbar problems or treatment; however, after her accident, she consistently complained of, and sought treatment for, ongoing lumbar issues. The MRI and EMG/NCS findings show that Petitioner's lumbar issues stemmed from a L4-L5 disc protrusion and lumbar radiculopathy. For these reasons, the Commission finds that Petitioner's current condition is causally related to the February 15, 2016 accident. The Commission otherwise affirms and adopts the Arbitrator's causal findings as to Petitioner's left shoulder injury.

b. *Temporary Total Disability*

In finding that Petitioner's current lumbar condition remained causally related to the work accident, the Commission finds that Petitioner is entitled to temporary total disability benefits from March 30, 2016 through the hearing date of September 12, 2019.

Petitioner was placed completely off work by Dr. Levi on March 30, 2016. Following that time, Petitioner was kept either off work or on light duty restrictions for her left shoulder and/or lumbar spine up until January 10, 2018, at which date Dr. Levi released Petitioner for her left shoulder injury with light duty restrictions pursuant to the functional capacity evaluation. Specifically, at that time, Dr. Levi released Petitioner with a 35-pound weight restriction with no over-shoulder work. However, on January 17, 2018, Dr. Levi made an addendum to that treatment note clarifying that although Petitioner was discharged for her shoulder, her lumbar spine remained painful. Dr. Levi referred Petitioner to Dr. Vo for further treatment for her lumbar spine. When Petitioner then saw Dr. Vo on January 24, 2018, he continued to keep her off work for her lumbar spine injury.

Shortly thereafter, on January 31, 2018, Respondent offered Petitioner a position that fell within the restrictions that Dr. Levi imposed on January 10, 2018. However, Petitioner did not accept this modified duty offer, because she remained on off-work restrictions for her lumbar spine

by her treating doctors. The treatment records confirm that Petitioner was kept completely off work for her back by her treating doctors after the job offer on January 31, 2018 until May 16, 2018, at which time Dr. Levi provided light duty restrictions. Despite the light duty release for Petitioner's lumbar spine, Respondent never subsequently offered her a light duty job after the first offer that was made in January 2018 for her left shoulder restrictions. Although Respondent indicated that Petitioner was no longer employed in its system, Petitioner testified that she never resigned nor quit from her employment with Respondent.

For the reasons previously discussed, the Commission finds that Petitioner's lumbar condition was more severe than merely a resolved lumbar strain as Dr. Butler contended. As such, the Commission is not persuaded by Dr. Butler's opinion that Petitioner could return to full duty work without restrictions for her lumbar spine injury. The Commission instead relies on the opinions of Petitioner's treating doctors and finds that Petitioner has proven her entitlement to temporary total disability benefits from March 30, 2016 through the hearing date of September 12, 2019 given that she remained on work restrictions for her lumbar spine injury.

c. *Medical Expenses*

The Commission further awards all reasonable and necessary medical expenses related to Petitioner's lumbar spine and left shoulder injuries incurred through the hearing date of September 12, 2019.

Given that the diagnostic studies show that Petitioner suffered from a symptomatic disc bulge and ongoing lumbar radiculopathy, the Commission is not persuaded by Dr. Butler's opinion that Petitioner reached MMI six to eight weeks after the accident as of June 15, 2016. Petitioner's lumbar MRI, EMG/NCS, and treating doctors' opinions all support the finding that Petitioner sustained more than a mere lumbar strain as Dr. Butler suggested. It so follows that the Commission is also not persuaded by Dr. Butler's opinion that the lumbar injections were neither reasonable nor necessary.

The Commission is further not persuaded by the UR's non-certification of significant portions of Petitioner's lumbar treatment. The Commission finds that it would be unreasonable to deny Petitioner's ongoing lumbar treatment given that her objective diagnostic studies verified that Petitioner suffered from a severe lumbar problem that became consistently symptomatic post-accident.

As for the medical expenses focused on Petitioner's left shoulder injury, Dr. Forsythe, the §12 examiner, opined that Petitioner's treatment had been reasonable and appropriate. He also recommended the rotator cuff repair surgery. Although the UR again non-certified some of Petitioner's shoulder treatment, the Commission awards all shoulder-related medical expenses up through the hearing date given that Respondent's §12 examiner agreed that the treatment had been medically necessary.

As such, the Commission modifies the award of medical expenses to extend through the hearing date of September 12, 2019 and include all reasonable and necessary medical expenses incurred for Petitioner's treatment of her lumbar and left shoulder injuries.

d. *Prospective Medical Care*

As the Commission has determined that Petitioner has not yet reached MMI for her lumbar spine injury, it accordingly vacates the award of 2% PAW in permanent partial disability related to Petitioner's low back injury. Instead, the Commission finds that Petitioner is entitled to the award of prospective medical care in the form of a lumbar spine surgical consultation.

On February 24, 2017 and March 24, 2017, PA Osmanski of MAPS referred Petitioner to a spinal surgeon for her continued lumbar radiculopathy. Shortly thereafter, on May 19, 2017, Dr. Pontinen specifically referred Petitioner to Dr. Salehi, a spine surgeon, for her low back pain. Although Dr. Levi then opined that he did not have any further treatment he could provide for Petitioner's lumbar spine as of May 16, 2018, he too recommended that Petitioner see a spine surgeon. Since the treatment providers at MAPS as well as Dr. Levi were in agreement that Petitioner should obtain a surgical consultation, the Commission awards prospective medical care for Petitioner's lumbar injury in the form of the recommended evaluation with a spine surgeon.

e. *Permanent Partial Disability*

In addition to vacating the permanent partial disability award for Petitioner's lumbar injury, the Commission further modifies the Decision of the Arbitrator to find that Petitioner sustained a loss of 15% PAW for her left shoulder injury based upon its analysis of §8.1(b) statutory factors.

In reviewing permanent partial disability for accidents occurring after September 1, 2011, the Commission must consider the §8.1(b) enumerated criteria, including (i) the reported level of impairment pursuant to (a) [AMA "Guides to Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability as corroborated by treating medical records. 820 ILCS 305/8.1b(b). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id*. § 305/8.1b(b)(v).

Regarding criterion (i), although Dr. Butler provided a 0% impairment rating for Petitioner's lumbar spine injury, no AMA impairment rating was presented for Petitioner's left shoulder injury. The Commission therefore assigns no weight to this factor.

Regarding criterion (ii), Petitioner was placed at a bakery in a packer position by Respondent's staffing agency on the accident date. However, since March 30, 2016, Petitioner has not worked for Respondent or any other employer. Although Petitioner never formally resigned nor voluntarily quit her employment with Respondent, Petitioner was told by Respondent in May of 2018 that she was no longer in their system or employed. Petitioner previously turned down one light duty job offer on January 31, 2018 from Respondent, because she remained on off-work restrictions for her lumbar spine by her treating doctors. At the time of the hearing, Petitioner was not conducting a current job search or actively seeking other employment within her restrictions. The Commission assigns moderate weight to this factor.

Regarding criterion (iii), Petitioner was 52 years old on the accident date of February 15,

2016. No direct evidence was presented as to how Petitioner's age specifically affected her disability. The Commission assigns some weight to this factor.

Regarding criterion (iv), there was also no direct evidence presented, including but not limited to a labor market survey, specifically speaking to Petitioner's future earning capacity. The Commission thus assigns no weight to this factor.

Regarding criterion (v), Petitioner treated for her left shoulder injury with a rotator cuff surgery, a shoulder injection, prescription medication, physical therapy, work conditioning, work restrictions, a Continuous Passive Movement Device, a Game Ready Cold Therapy System, and a TENS unit. On January 10, 2018, Dr. Levi released Petitioner from care for her left shoulder with a 35-pound weight restriction with no over-shoulder work pursuant to the FCE.

Petitioner testified that she felt better for a couple months after her left shoulder surgery, but her arm has since started to hurt again. Petitioner further testified that she can no longer lift heavy objects with her left arm, including holding a gallon of milk like she can with her right arm. Her left shoulder also hurts and pulsates whenever the weather changes. Nevertheless, Petitioner was no longer taking any prescription medications at the time of the hearing aside from her unrelated diabetes medication. The Commission assigns significant weight to this factor.

Upon consideration of these factors, particularly Petitioner's need for surgical intervention and permanent 35-pound restrictions, the Commission finds that Petitioner sustained a loss of 15% PAW for her left shoulder injury. Although she no longer requires prescription medication, Petitioner continues to experience ongoing left shoulder symptoms that affect her daily life. The Commission modifies the Decision of the Arbitrator accordingly.

For all other issues not specifically modified herein, the Commission affirms and adopts the Decision of the Arbitrator, including but not limited to the Arbitrator's denial of penalties and attorney's fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 14, 2020 is modified as stated herein only with respect to 16 WC 9582.

IT THEREFORE FOUND BY THE COMMISSION that the current condition of Petitioner's lumbar spine, which includes a L4-L5 disc protrusion and lumbar radiculopathy, is causally related to her work accident on February 15, 2016. The Commission otherwise affirms and adopts the Arbitrator's causal findings as to Petitioner's left shoulder injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $294.84 per week from March 30, 2016 through the hearing date of September 12, 2019, which represents a period of 180 2/7 weeks, in accordance with §8(b) of the Illinois Workers' Compensation Act. As provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all

reasonable and necessary medical expenses related to Petitioner's left shoulder and lumbar conditions through the hearing date of September 12, 2019 pursuant to §8(a) and §8.2 of the Act. This award includes, but is not limited to, the injections for Petitioner's lumbar spine and is not impacted by the UR findings.

IT IS FURTHER ORDERED BY THE COMMISISON that Respondent is liable for prospective medical care for Petitioner's causally related low back condition, including recommended consultation with a lumbar spine surgeon.

IT IS FURTHER ORDERED BY THE COMMISSION that the permanent partial disability award of 2% PAW for Petitioner's lumbar spine injury is vacated, as Petitioner has not yet achieved MMI for his lumbar condition. However, for Petitioner's left shoulder injury, the Commission orders Respondent to pay Petitioner the sum of $265.36 for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a loss of 15% PAW.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's denial of penalties and attorney's fees under §19(k), §19(l), and §16 of the Act is affirmed.

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

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

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

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.

August 9, 2021

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

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

DLS/met
O- 6/9/21
46

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0405

NOTICE OF ARBITRATOR DECISION

SECTION 19K 19L 16 PENALTIES

RODRIGUEZ, MARIA
Employee/Petitioner

Case# **16WC009581**

16WC009582

LABOR NETWORK INC
Employer/Respondent

On 5/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
PETER HAVIGHORST
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
SECTION 19K, 19L, 16 PENALTIES

MARIA RODRIGUEZ
Employee/Petitioner

v.

LABOR NETWORK, INC.
Employer/Respondents

Case # 16WC009581; 16WC009582

Consolidated cases: Y

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 9/12/2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 3/25/15 and 2/15/16 Respondent **was** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,934.11;** the average weekly wage was **$442.26**.

On the date of accident, Petitioner was **52** years of age, ***unmarried***, with ***no*** dependents.

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 **$18,850.52** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for medical benefits.

Respondent has also paid **$2,653.50** in PPD advance, and shall be given a credit for same.

ORDER

The Arbitrator concludes that Petitioner failed to prove she sustained an injury to her right leg as a result of any work accident, which was in controversy at trial.

The Arbitrator concludes that Petitioner proved she sustained an injury to her left shoulder which arose out of and in the course of her employment. The Arbitrator further concludes that Petitioner proved she suffered an injury to her lumbar spine which arose out of and in the course of her employment. The Arbitrator denies to award any further medical care or treatment, which was in controversy at trial.

The Arbitrator finds that Petitioner sustained disability to the extent of 12% loss under 8(d)2 for her left shoulder injury (60 weeks), and 2% loss under 8(d)2 for her lumbar spine injury (10 weeks). In total, Petitioner is entitled to 70 weeks of permanent partial disability *minus* the 10-weeks of PPD previously paid by Respondent.

The Arbitrator concludes Petitioner did not prove the entitlement to any additional Temporary Total Disability benefits than those already paid through January 31, 2018, and none are awarded.

The Arbitrator finds that Respondent is only responsible for medical bills listed in Petitioner's exhibits specifically pertaining to her left shoulder and lumbar back, as limited by the medical fee schedule or negotiated rate. The Respondent is not responsible for any medical bills pertaining to injections for Petitioner's back. The Respondent is not responsible for medical bills listed in Petitioner's exhibits after the date of January 18, 2018, and as further limited by the additional findings in the written decision.

The Arbitrator additionally finds that no penalties or fees are to be awarded.

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

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

Signature of Arbitrator

May 11, 2020
Date

MAY 14 2020

ICArbDec19(b)

Maria Rodriguez,
Employee/Petitioner

Case # **16WC9581; 16WC9582**

v.

Consolidated / Watts

Labor Network, Inc.
Employer/Respondents

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties agree that on both 3/26/2015 and 2/15/2016, the Petitioner, Maria Rodriguez and the Respondents, Labor Network, Inc., were operating under the Illinois Workers' Compensation Act, and that their relationship was one of employee and employer. They also agree that Petitioner was unmarried, with no dependents at the time of the alleged accidents. Notice was not disputed.

At issue in this hearing is as follows:

(1) Whether two separate accidents occurred involving Petitioner, arising out of and in the course of her employment, involving her right knee, left shoulder and lumbar back;
(2) Whether the Petitioner's current condition of ill-being of her back is causally connected to the alleged work incident;
(3) Whether Petitioner is entitled to payment of medical bills;
(4) Whether Petitioner is entitled to Temporary Total Disability benefits;
(5) Whether it is appropriate and how much to award an amount for the nature and extent of Petitioner's injury; and
(6) Whether the imposition of any penalties or attorneys' fees is appropriate.

FINDINGS OF FACT

This matter was tried on September 12, 2019, by agreement of the parties. Petitioner was the lone witness at trial. Petitioner testified through an interpreter that she began to work for Respondent, a labor agency, in March of 2015 (Tr. P. 10). On 3/26/2015, she claimed to suffer an injury to her right knee when she slipped and fell forward. She blamed the cause of the injury on her shoes (Tr. P. 11). Petitioner did not testify with any specificity concerning the alleged accident, except that it took place. Petitioner did not state where it took place, at what time, if there were any witnesses, and she did not claim to miss any work from the incident (Tr. P. 11). She did file an Application concerning the incident which was assigned Case No. 16WC009581 by the Commission.

Petitioner further testified that on 2/15/2016, she was working for the Aryzta Bakery, having been placed in a packing position by Respondent (Tr. P. 12). In this job she was responsible for packing individual wrapped breads into boxes and also picking up material off the bakery floor Tr. P. 12). Petitioner stated that while lifting up a box filled with product, weighing approximately 40-pounds, she started to walk

and slipped, falling backwards (Tr. P. 13). She thought there was some grease or butter on the floor (Tr. P. 14). Petitioner stated she fell to the ground, and injured her left shoulder when it struck a pallet (Tr. P. 14-15). She immediately reported what had happened to her Supervisor (Tr. P. 15).

Petitioner was sent to Physician's Immediate Care ("Physicians") where she was treated for her left shoulder pain. Although some notes from Physician's mistakenly list right arm pain, Petitioner was always treated for her left shoulder (Tr. P. 18). After x-rays were completed, Petitioner was diagnosed with a contusion of her shoulder and was given extra-strength non-aspirin for pain with a release back to work without any restrictions (Ex. P. 1).

On February 22, 2016, Petitioner returned to Physicians for a follow-up visit complaining of continued pain in her shoulder (Tr. P. 20). She was released with restrictions to avoid strong gripping and repetitive motion with her left arm (Tr. P. 20). These restrictions were considered light duty, and Petitioner continued to work over the next several weeks (Tr. P. 21).

At an evaluation with Dr. Levi on March 30, 2016, the physician administered a pain injection in Petitioner's left shoulder (Tr. P. 22). Dr. Levi stated Petitioner could remain off work because of her shoulder pain, and he had her begin physical therapy at his office (Tr. P. 23). Petitioner continued to work. Her last date of work was June 6, 2016, as noted in Respondents' Wages and TTD ledger (R. Ex. 8).

On June 1, 2016, Petitioner had two separate MRI examinations, of her left shoulder and lumbar back. The exams (P. Ex. 8), concluded:

- Left shoulder: intact labrum and intact long head of biceps tendon; full thickness tear in the rotator cuff tendon; AC joint demonstrated osteoarthritic changes.
- Lumbar: normal lumbar curvature; no significant fractures or subluxations; bone marrow unremarkable; at L4-L5 a 2mm anterior disk bulge; all other disks in tact with normal soft tissue and all visible portions of the lumbar spine normal.

On October 13, 2016, Dr. Forsythe performed an independent medical examination on Petitioner (R. Ex. 1). After his review of all available medical records and an in-person assessment, Dr. Forsythe diagnosed a left shoulder rotator cuff tear, and he recommended a surgical repair (R. Ex. 1). He also recommended that the Petitioner could return to work at a 5-pound restriction for her left arm (R. Ex. 1).

On March 6, 2017, Petitioner underwent arthroscopic rotator cuff surgery for repair of her left shoulder.

On March 8, 2017, Respondent issued Petitioner a check in the amount of $5,014.66 for 17 weeks of past total temporary disability benefits, dating back to her last date of work (June 6th). Petitioner testified that after her surgery she received weekly checks from Respondent while she remained off work (Tr. P. 30).

On July 3, 2017, Petitioner began a physical therapy regimen, and by July 28th, she had completed ten sessions. At the time she reported a 75% improvement in her left shoulder, with increased use of her left arm and hand that included increased household activities.

By November 15, 2017, Petitioner was 7.5 months since her shoulder surgery, and she was recommended for a work conditioning program. Petitioner began work conditioning for 5-days per week for four weeks.

On December 29, 2017, a work conditioning progress report was issued which stated Petitioner had attended 19 sessions, the left shoulder felt better with minimal to no pain. Petitioner was able to reach overhead in all directions, and work conditioning was no longer recommended.

On January 2, 2018, the Petitioner attended a Functional Capacity Examination. During the exam, she had some complaints of left shoulder pain with repetitive activities, and she was ultimately assessed at the medium duty physical demand level.

On January 10, 2018, Petitioner returned to meet with Dr. Levi who concluded she had improved to the point she was no longer taking any pain medication. He determined she was able to return to work and lift 35 pounds, and he discharged her from any further care.

On January 31, 2018, Respondent sent a formal correspondence to Petitioner notifying her of an available position (R. Ex. 3). The correspondence noted the condition that Petitioner had to comply with the return to work policies and report to work by February 5, 2018 (R. Ex. 3).

Petitioner testified that she had received the letter (Tr. P. 36), but she did Petitioner did not report to work for the position. Petitioner further testified that she did not make contact with Respondent concerning a return to work until May 2018 (Tr. P. 37).

On May 22, 2018, Dr. Jesse Butler complete an independent medical examination regarding Petitioner's lumbar back (R. Ex. 2). After his review of the medical records, including the MRI, EMG study, FCE, and all of Petitioner's physical therapy notes, Dr. Butler concluded the Petitioner had a normal evaluation for a woman Petitioner's age (55 years old). In all, he diagnosed a resolved lumbar strain, and found:

- No objective pathology affecting her disks, and no objective findings to support ongoing complaints of pain and prolonged treatment for her back;
- No active work-related phenomenon affecting her lumbar spine, and no current causal relationship;
- Spinal injections were neither reasonable nor necessary for what Petitioner stated happened at work; and
- Petitioner had reached maximum medical improvement by 6-8 weeks after the strain, and required no treatment after June 15, 2016 related to her back.

Petitioner testified that as of the date of trial, she has not returned to work in any capacity. She submitted as part of her testimony various medical bills and treatment records pertaining to care for her lumbar back.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file.

In connection with the Arbitrator's Decision regarding Issue C, whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent; Issue F, is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator concludes as follows:

The Arbitrator notes that it is well established that a Petitioner carries the burden of proving her case by a preponderance of the evidence. "Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Parro v. Industrial Commission*, 630 N.E.2d 860 (1st Dist. 1993); *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

Among the factors to be considered in determining whether a claimant has sufficiently carried her burden is her credibility. See, *Parro*, supra. Credibility is the quality of a witness, which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony.

The Commission is not required to find for a claimant merely because there is some testimony which, if it stood alone and undisputed, might warrant such a finding. *Burgess v. Industrial Commission*, 523 N.E.2d 1029 (1st Dist. 1988). The mere existence of testimony does not require its acceptance, *U.S. Steel Corporation v. Industrial Commission*, 8 Ill. 2d 407 (1956), and the Commission is not required to accept unrebutted testimony. *Sorenson v. Industrial Commission*, 281 Ill.App.3d 373, 384 (1996). Where the sole support for an award rests on the claimant's own testimony, and claimant's actual behavior and conduct is inconsistent with that testimony, 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). Moreover, the Commission does not

To determine whether a claimant has met his requisite burden of proof by a "preponderance of credible evidence," it is necessary for the Commission to look for consistency and corroboration between a witness' testimony, conduct, and other documentary evidence to determine the truth of the matter. Where that other evidence tends to impeach or undermine a claimant's testimony, there may be sufficient cause to find that a claimant has failed to meet his requisite burden.

Petitioner's credibility overall was uneven. Her demeanor at trial seemed sincere and there were no outward signs that she was searching for words or that she was inconsistent. Rather, it is the actual testimony that does not add up with regard to the claimed knee injury but is consistent with the record and standing alone with regard to the second claimed injury to her shoulder and back. The Arbitrator also finds that Petitioner was prone to exaggeration of symptoms and post-injury limitations. Given the unevenness and exaggerations, the Arbitrator finds the medical record more persuasive when there is a contradiction.

Specifically, concerning the alleged incident of 3/26/2015, after considering the credibility of Petitioner, submitted records and evidence, the Arbitrator concludes that Petitioner did not prove that she sustained an accident that arose out of and in the course of her employment with Respondent.

Concerning the alleged incident of 2/15/2016, the Arbitrator concludes that Petitioner suffered a left rotator cuff injury and a mild lumbar strain which arose out of and in the course of her employment with Respondent. The evidence submitted at trial details the extent of the accidents which occurred. Petitioner eventually underwent approved surgery for her rotator cuff, and that injury was resolved by January 18, 2018. Petitioner suffered a mild back strain, which was resolved within six weeks after the accident (by 03/28/2016). Petitioner's sworn testimony that her lumber injury did not resolve directly contradicts the medical records, and so is unpersuasive on this point.

First, the work accident as described by Petitioner's testimony does not support an injury to her back beyond a lower back contusion. Petitioner testified that she did not land on her back, but that she hit against the pallet as she fell to the ground (Tr. P. 14). It was her left arm and shoulder that bore the brunt of her slip and fall. During the incident, she tore her rotator cuff. All subsequent x-rays and MRI's did not show support for an impairment of her back to any degree beyond a strain.

Second, during all of the initial visits for physical therapy for her shoulder, and then subsequent to her surgery, Petitioner did not seek out any therapy for her back. Petitioner only sought additional treatment when she was released from shoulder care and was confronted with returning to work.

Third, Dr. Butler credibly and conclusively determined that Petitioner had no pathology for any continued back complaints beyond six weeks after the original fall. When he met Petitioner more than two years after the original incident, he found multiple inconsistencies with her complaints compared to her clinical exams. Nowhere in her MRI or x-rays did he find support for her back complaints and he definitely concluded there were no objective findings to keep her from working at full duty.

Fourth, the submitted utilization review report and subsequent supplemental report (R. Ex. 5 & 6) conclusively found a substantial portion of the medical care was not reasonably required to cure the effects of injury to Petitioner's back. This included the non-certification of equipment [the Tens unit], numerous medications, and back injury treatment [injections].

Finally, Petitioner's testimony is suspect and unreliable. Despite all of the physician's involved in her care agreeing that she can lift 35-pounds with her left arm, Petitioner testified that she cannot hold a gallon of milk (Tr. P. 43). Far more than a legitimate doubt exists about the extent of Petitioner's injuries as she testified to at trial, and a decision cannot be based on speculation or conjecture. *See, Deere & Co. v. Industrial Commission,* 47 Ill.2d 144, 148 (1970); *First Cash Financial v. IWCC*, 367 Ill.App.3d 102, 106 (2006); *Carter v. Azaran*, 332 Ill.App.3d 948, 961, 774 N.E.2d 400 (2002). The Arbitrator takes specific notice that while Petitioner was the lone witness at trial, her testimony regarding the extent of her lumbar injury is rebutted by the plain reading of the MRI and FCE reports, the IME expert Dr. Butler, the physician-reviewed utilization reviews, and her own physician. Thus, on the extent of injury, the Arbitrator choses to rely on the medical record and the IME reports.

After considering witness' testimony at trial, submitted medical records and physician evaluations, the Arbitrator concludes that Petitioner proved a causal connection to an injury to her left shoulder and lumbar back, which both resolved. Petitioner did not prove he suffered an injury to any other body part.

In connection with the Arbitrator's Decision regarding Issue J, whether the medical services that were provided to Petitioner and related medical bills are reasonable and necessary, the Arbitrator concludes as follows:

The Arbitrator has rendered a decision, separately, finding that an accident arose out of and in the course of Petitioner's employment, and Petitioner suffered an injury to her left shoulder and her lumbar back. The Arbitrator further finds that Petitioner incurred medical fees for treatment related to her left shoulder and lumbar back and that bills related to her treatment were entered into evidence at trial.

The Arbitrator concludes that Petitioner has met her burden of proof on medical bills owed on her left shoulder. These bills are limited to those occurring before the date of January 18, 2018 when Petitioner's physician placed her at maximum medical improvement and released her from any shoulder care. There is no liability for Respondent for any bills for care after that date. The Arbitrator further finds that the bills are limited by the findings contained in Respondent's Utilization Review Reports (R. Ex. 5 & 6), which denied specific treatments and instances of coverage.

The Arbitrator concludes that Petitioner has met her burden of proof on medical bills owed on her lumbar back. These bills are limited to those occurring before the date of June 15, 2016, when the IME physician Dr. Butler determined all care for the lower back was resolved. The Arbitrator further finds that the bills are limited by the findings contained in Respondent's Utilization Review Reports (R. Ex. 5 & 6), which denied specific treatments and instances of coverage.

As such, and according to the specific limitations, the Arbitrator orders payment of the submitted medical bills, as limited by the Medical Fee Schedule.

In connection with the Arbitrator's Decision relating to Issue K, whether Petitioner is entitled to Temporary Total Disability (TTD), the Arbitrator concludes as follows:

For Petitioner to be entitled to temporary total disability benefits under the Illinois Workers' Compensation Act, she must prove she is "totally incapacitated for work by reason of the illness attending the injury." *Mt. Olive Coal Co. v. Industrial Commission*, 129 N.E. 103, 104 (Ill. 1920). Temporary total disability exists from the time an injury incapacitates an employee for work until such time as she is as far restored as the permanent character of her injury will permit. *Shell Oil Co. v. Industrial Comm'n*, 2 Ill.2d 590 (1954). To prove entitlement to any temporary total disability, Petitioner must show not only that she did not work but also that she was unable to work. *Schmidgall v. Industrial Comm'n*, 268 Ill.App.3d 845, 847 (4th Dist. 1984); *Boker v. Industrial Comm'n*, 141 Ill.App.3d 51, 55, 489 N.E.2d 913 (3d Dist. 1986).

The Arbitrator concludes that Petitioner has proven that the injury she sustained to her left shoulder and lumbar back. These required medical care and treatment which kept her off work. The Arbitrator finds that based upon the parties' stipulation, and Respondent's ledger of TTD and wages (R. Ex. 8), Petitioner was paid TTD payments from 6/6/2016, through 2/14/2018.

The Arbitrator further concludes that Petitioner was entitled to TTD from 6/6/2016 through 1/18/2018, at which time she was released from all further care for her shoulder by her physician. She had previously been placed at MMI for her lumbar injury. The Arbitrator additionally finds that Petitioner has failed to prove she was totally incapacitated for work for the time period after 1/18/2018, by reason of the illness attending the injury. Respondent is entitled to a credit for the full amount of paid TTD to Petitioner.

In connection with the Arbitrator's Decision regarding Issue L, what is the Nature and Extent of the Injury, the Arbitrator concludes as follows:

Pursuant to Section 8.1b(b) of the Act, the Arbitrator addresses Petitioner's permanent partial disability as follows:

i. Petitioner is not currently working although she was placed at MMI by Dr. Levi and Dr. Butler. Dr. Butler has also included an impairment rating of 0% for Petitioner's back injury. The Arbitrator gives these submissions medium weight.

ii. Petitioner's occupation at the time of the accident was as a packer, on the production-line of the bakery facility. On the trial date, Petitioner had been at full-duty work for her back for over two years, and placed at maximum medical improvement for her shoulder for over a year and a half. Petitioner testified that she had not attempted to return to work under Respondent's employment despite a job offer being made when she was released from care for her shoulder. Finally Petitioner testified that she had not attempted to secure a new job, or put together a job search (Tr. P. 53) since the incident. The Arbitrator gives this factor medium weight.

iii. Petitioner was 52 years of age at the time of the accident, which means she has a long work/career ahead of her. Therefore, the Arbitrator gives minimal weight to this factor.

iv. Petitioner has not proven her future earning capacity was affected by the accident. Petitioner was released to return to work, and chose not to attempt to secure a new job or put together a resume or a job search. The Arbitrator gives minimal weight to this factor.

v. Petitioner testified she still experiences discomfort in her back and sometimes in her left shoulder. Petitioner testified that she does not use any over the counter pain medications, although she did not state why not. The Arbitrator gives minimal weight to this factor.

After applying the facts of the instant case to the factors enumerated by Section 8.1b of the Act, the Arbitrator determines Petitioner has proven partial permanent disability in the amounts as follows:

- Concerning her left shoulder, 12% loss under 8(d)2 (or 60 weeks of PPD);
- Concerning her lumbar back, 2% loss under 8(d)2 (or 10 weeks of PPD); and
- Calculated in the final award, Respondent will be given credit for the previously issued check for 10 weeks of PPD [$2633.50].

In connection with the Arbitrator's Decision regarding Issue (M), whether Penalties or Fees shall be imposed upon Respondent, the Arbitrator concludes as follows:

Petitioner filed its Petitioner for Penalties and Fees pursuant to Sections 19(k), 19(L) and 16, and Respondent filed a timely response. The Arbitrator has already rendered a decision, separately, on accident and causal connection, medical bills, temporary benefits, and the nature and extent of Petitioner's injuries. Based upon the submitted medical records and testimony, the Arbitrator further concludes that Petitioner is not be entitled to penalties or fees, and none are awarded.

It is well-settled that the imposition of penalties and attorneys' fees under Section 19(k) and Section 16 is discretionary. *McMahan v. Industrial Comm'n*, 183 Ill.2d 499, 515 (1998). The standard for awarding penalties and attorney fees under Sections 19(k) and 16 is higher than the standard for awarding penalties under Section 19(L). *McMahon*, 183 Ill.2d at 515. It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause to award penalties under Sections 19(k) and 16. Both require a vexatious delay in payment. *Vulcan Materials Co. v. Industrial Comm'n,* 362 IllApp.3d 1147, 1150 (2005).

An employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act. *Matlock v. Industrial Comm'n*, 321 Ill.App.3d 167, 173 (2001). Where an employer is in possession of facts that would justify a denial of benefits, penalties and fees are generally inappropriate. *ElectroMotive Division v. Industrial Comm'n*, 250 Ill.App.3d 432, 436 (1993). Good faith must be assessed objectively, thus the question is whether an employer's denial of benefits was reasonable. *ElectroMotive*, 321 Ill.App.3d at 436. The employer bears the burden of demonstrating that its denial of benefits was reasonable. Id.

Respondent did not engage in an unreasonable and vexatious delay in payment of any benefits. Respondent had Petitioner evaluated for an IME with its physician, and relied upon its IME physician's findings before it agreed to authorize shoulder surgery. It then remitted payment for prior TTD to Petitioner. Based upon the surgery and subsequent treatment which kept Petitioner off work, Respondent continued to make weekly TTD payments. Once Petitioner was found to have completed all shoulder care, Respondent terminated any additional TTD benefits. Respondent's reliance on its expert's clinical assessment was not unreasonable, and Respondent's actions do not rise to the threshold level of callousness required for an imposition of penalties and fees under Sections 19(K), 19(l) and 16. This holds for consideration of the shoulder and the lumbar injury, as well as any medical bills.

Respondent did not engage in an unreasonable and vexatious delay in payment of any medical bills. To the contrary, Respondent made a good faith attempt to process the bills and match its responsibility for payment. To wit, Respondent raised a valid defense to any penalties or fees on medical bills on two basis: one, based upon its reliance on its expert's opinions on causation and the nature and extent of any back injuries (through IME); and two, Respondent's sought-after evaluation of medical treatment and bills via a utilization review.

Key here is the fact that Petitioner only turned over its final tally of all the medical bills on April 22, 2019. Immediately thereafter, Respondent had the billings submitted to utilization review, and received

its UR analysis within 60-days – a evaluation which took into account billings from 15 separate providers that totaled a claim for over $250,000.00.

It is well settled that Section 8.7(i) indicates that a utilization review "will be considered by the Commission, along with all other evidence and in the same manner as all evidence, in the determination of the reasonableness and necessity of the medical bills or treatment." *Hardy v. Murray Developmental Center*, 07 WC 48727, 09 I.W.C.C. 0725, 2009 WL 2516197 (July 15, 2009). The aspiration and then actual securing of a utilization review on the medical bills cannot be considered vexatious nor a delay tactic by Respondent.

Moreover, herein Respondent made a 'good-faith' offer of ten weeks of PPD to this Petitioner, in order to ensure there was no untimely or damaging wait by Petitioner for the UR analysis to be concluded.

Finally, the Arbitrator has found that Petitioner exaggerated both her symptoms and supposed physical limitations. The Arbitrator does not take the opportunity to use his discretion, in light of all the other reason discussed above, to award penalties to someone who is not completely forthright.

The Arbitrator concludes that the cumulative actions of Respondent were not unreasonable and do not prove a level of callousness required for an imposition of penalties and fees under Sections 19(K), 19(l) and 16.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC006821
Case Name	ROBLEDO, ANTONIO v. FOUR SEASONS HVAC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0406
Number of Pages of Decision	22
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Ian Fuller
Respondent Attorney	Ian Fuller

DATE FILED: 8/9/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTONIO ROBLEDO,

Petitioner,

vs. NO: 18 WC 6821

FOUR SEASONS HVAC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, benefit rate/average weekly wage, temporary total disability, permanent partial disability, medical expenses both current and prospective, denial of the imposition of penalties and fees, and the propriety of the Arbitrator's denial of Petitioner's Motion to Re-Open Proofs, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner testified he worked for Respondent for nine years as an HVAC installer. On June 27, 2017, he was removing a unit from the roof of a building. He had to take a compressor down four flights of stairs and put it in his vehicle. In so doing, he felt a strain in his back. He continued to work that day. He worked the next day, but he had pain in his hips and had difficulty using stairs. The next day, he was assigned to another roof-top job. He did not believe he could perform that job on that day, reported the accident he had two days earlier, and asked for a lighter assignment. Respondent immediately sent him for treatment at Concentra, the company clinic. He was placed on light duty at that time and had physical therapy and injections which did not provide significant relief.

When Petitioner was placed on light duty after his initial visit to Concentra, he was moved to the parts department where he performed clerical work with no lifting required. He continued to work in that capacity through the date of arbitration. Petitioner testified that at the time of the accident, he was paid @ $35 an hour with mandatory overtime. Sometimes he worked more than 20 or 25 hours shifts, his longest shift was 30 hours. His work was seasonal. Summer and Winter were busy but in the other seasons he worked once or maybe twice a week. He has been on light duty since he first went to Concentra. He was currently working full time as a parts clerk earning $21 an hour.

Mr. John Coggins was called to testify by Respondent for which he worked as Director of Warehouse Operations. He worked there since 2002. He was currently Petitioner's supervisor in the parts department. He characterized Petitioner's work in the parts department as "above average;" he had not had to reprimand him. Petitioner was working full time earning $20.86 an hour. Petitioner also earned overtime in the parts department and was going to get a raise soon. Boiler installers are paid an hourly rate with "a performance-based pay component based on the model or the type of job."

On cross examination, Mr. Coggins testified he did not know whether Petitioner had installed boilers. He expected Petitioner to get a raise when he moves him to a different position using his field knowledge. It is a more stressful position and some employees decline the reassignment, but he expected Petitioner to excel. There were three other employees who have the same assignment as Petitioner who all earn less than Petitioner. Nevertheless, Mr. Coggins did not believe Petitioner was overpaid because of his experience as an installer. He believed the person with the same job title as Petitioner earning the least money made $15.80 an hour.

On redirect examination, Mr. Coggins testified that Petitioner was the only parts-person with field experience. Petitioner had a strong aptitude in processing installation jobs. He would look for more employees with Petitioner's experience to work that job at Petitioner's rate of pay.

Petitioner's lumbar MRI taken on August 3, 2017 showed central posterior annular tear at L4-5, which might cause pain and a mild disc protrusion causing moderate bilateral neural foraminal stenosis at L4-5. A thoracic MRI taken on February 2, 2018 for thoracic pain after a work injury in August 2017 showed thoracic degenerative disc disease with no obvious spondylolysis or listhesis, a 3.5 millimeter disc protrusion causing mild central canal stenosis at T6-7, a two millimeter disc protrusion at T7-8, and similarly sized disc protrusions with no significant stenosis at T8-9, T10/11, and T11-12. Petitioner was deemed not to be a surgical candidate, by two surgeons. An FCE was ordered. Petitioner was deemed to give full effort throughout and the FCE determined that Petitioner could work at the medium physical demand level. However, his job as HVAC installer required a heavy physical demand level.

The FCE recommended work hardening. However, because of the accumulation of previous work injuries as well as the instant injury, his doctor declined to prescribe work hardening and instead imposed permanent restrictions based on the results of the FCE. Those restrictions precluded Petitioner from returning to work at his previous job as HVAC installer.

After the Arbitrator issued his decision, Petitioner moved to recall the decision, reopen proofs, and petitioned for maintenance and vocational rehabilitation, apparently after Petitioner was laid off. Petitioner argued that the Arbitrator was misled by Respondent's witness, Mr. Coggins, in indicating that Petitioner's job in the parts department was permanent and not a sham. He cited other workers who had the same job title as Petitioner but were paid less.

Respondent objected to Petitioner's petition arguing that economic circumstances is not a basis to recall an opinion or reopen proofs, Petitioner's job was permanent, his lay off was due to COVID, and the Arbitrator did not have jurisdiction to recall the decision. The Arbitrator denied the motion based on his lack of jurisdiction. We agree with the Arbitrator that he did not have jurisdiction to re-open proofs after his decision was issued and affirms his denial of Petitioner's Motion to Re-Open Proofs.

Petitioner submitted into evidence all of his pay records from the relevant period of time. The exhibit indicates that in the 52-weeks period immediately prior to the accident, Petitioner earned $42,070.88. However, the exhibit also indicates that there were periods of time during that 52-weeks period in which Petitioner was not working. The Act specifies that if a claimant loses more than five calendar days of work during the 52 weeks prior to the accident, average weekly wage shall be calculated by dividing the number of weeks and parts thereof remaining after that time so lost has been deducted. *See*, 820 ILCS 305/10. In the instant case, Petitioner lost more than five calendar days of work in the 52 weeks prior to the accident.

The Arbitrator calculated an average weekly wage at $854.61. He did so by dividing what he determined to be Petitioner's annual income prior to the accident by 52 weeks. However, according to the Act, and subsequent case law, Petitioner's income for the period must be divided by the actual number of weeks he worked to establish his average weekly wage. *See also, Sylvester v. Illinois Industrial Commission,* 197 Ill. 2d (2001). Therefore, the Commission takes his total income from the 52 weeks prior to the accident ($42,070.88) and divides it by the actual number of weeks worked during that period (36.8) and calculates Petitioner's average weekly wage to be $1,143.23.

Based on our calculation of Petitioner's average weekly wage, the Commission finds that Petitioner is entitled to a wage differential. The testimony and wage records indicate that after the accident Petitioner earned $20.86 an hour in a full-time job in Respondent's part department. However, Respondent's witness testified that Petitioner earned more than any of the other three employees in the parts department who had the same job title as Petitioner.

In addition, Petitioner presented evidence of the wages of those other three employees, who earned $15.48, $16.82, and $16.70 per hour respectively. Those salaries average earnings of $16.33 an hour, which the Commission deems to be the actual value of the work Petitioner performed while on restricted duty. That equates to a post-accident average weekly income of $653.20. For an award for wage differential, the Act specifies that a claimant shall receive 66&2/3 percent of the difference of income they received prior to the injuries and the amount he could earn after the injuries. We calculate the wage differential to be $326.02 a week.

Furthermore, based on our finding on average weekly wage and Petitioner's entitlement to an award for wage differential, the Commission also finds that Petitioner is entitled to temporary partial disability benefits from the time Petitioner was placed on light duty, June 30, 2017, through the date he was released to work with permanent restrictions and was released from treatment, December 8, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated May 21, 2020 is modified as specified above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award for permanent partial disability is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $7,591.38 because the injuries sustained caused a diminution of Petitioner's income between June 30, 2017 through December 8, 2017 under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $869.93 for medical expenses under §8(a) and §8.2 of the Act.

IT ISFURTHER ORDERRED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits commencing December 8, 2017 in the sum of 326.02 per week for the duration of the disability, because the injuries sustained caused a loss of earning, as provided under §8(d)1 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $70,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 9, 2021

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

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

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

DLS/dw
O-6/9/21
46

ROBLEDO, ANTONIO
Employee/Petitioner

Case# **18WC006821**

FOUR SEASONS HEATING & AIR CONDITIONING INC
Employer/Respondent

On 5/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5570 JACKOWIAK LAW OFFICES
LAWRENCE JACKOWIAK
111 W WASHINGTON ST SUITE 1500
CHICAGO, IL 60602

5074 QUINTAIROS PRIETO WOOD & BOYER
IAN FULLER
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

A Robledo v. Four Seasons, Inc., 18 WC 06821

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

ANTONIO ROBLEDO
Employee/Petitioner
v.
FOUR SEASONS HEATING & AIR CONDITIONING, INC.
Employer/Respondent

Case # 18 WC 06821

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 **August 13, 2019 and September 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

A Robledo v. Four Seasons, Inc., 18 WC 06821

FINDINGS

On **June 27, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **44,439.69**; the average weekly wage was **$854.61**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **1** dependent children.

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 under Section 8(j) of the Act as is set forth below.

ORDER

Respondent shall pay reasonable and necessary medical services of $869.93, as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below. No prospective medical treatment is awarded.

Respondent shall pay Petitioner permanent partial disability benefits of $512.76 per week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's claim for Penalties and Fees is denied.

Respondent shall pay Petitioner all awarded compensation that has accrued from 6/27/2017 to 9/16/2019 in a lump sum and shall pay the reminder 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

May 17, 2020
Date

ICArbDec p. 2

MAY 21 2020

FINDINGS OF FACT

Testimony:

As of the first date of trial, August 13, 2019, Petitioner has been employed continuously by Respondent for over nine years. He had attended a HVAC institute for 8 months in 2008 and thereafter worked for 11 months in the HVAC industry in San Antonio before being hired by Respondent. He began as an installer helper and progressed to the lead installer job classification. This is a physical job, involving the installation of air conditioners, furnaces and related equipment.

On the day of the accident, June 27, 2017, Petitioner was working for Respondent as a lead installer. While working at a job at a customer's house, Petitioner had to carry a heavy air conditioner compressor down about four flights of stairs and across the street to a truck. When he loaded it into the truck, he felt a strain in his back. He went back to the shop.

Petitioner hoped that he could rest it off and feel better. The next day, his back felt worse, but he tried to go to work. As soon as he went to the jobsite, he felt pain in his hips, and it was hard to go up and down stairs. He finished out his work for the day. The next morning, he told his supervisor, Mike Cirar, about his back. Petitioner was being assigned a rooftop job, and he said he couldn't do it, and asked for something lighter to do. His supervisor told him to go to the company clinic, Concentra.

Petitioner first presented to Concentra on June 30, 2017, and made several visits after that in July, August, September and October of 2017. Petitioner initial treatment was physical therapy, which he explained made the condition worse. An MRI was ordered, then Concentra referred Petitioner to a physiatrist, Dr. Sajjad Murtaza. Petitioner treated with Dr. Murtaza and received an epidural steroid injection.

Next, Concentra referred Petitioner to Dr. Sean Salehi, a neurosurgeon. Dr. Salehi reviewed the MRI and referred Petitioner for a functional capacity evaluation (FCE). After the FCE, Dr. Salehi prescribed permanent work restrictions. Dr. Salehi opined that Petitioner was not a surgery candidate.

After being released by Dr. Salehi, Petitioner presented to his primary care doctor, Rathna Yallapragada, for another opinion. Dr. Yallapragada referred him to a neurosurgeon, Dr. Anthony DiGianfilippo, who also said Petitioner was not a surgery candidate. Then Dr. Yallapragada referred Petitioner to Dr. Khan, a pain management doctor, and Petitioner had another MRI. Dr. Khan recommended a discogram, but Petitioner chose not to have one. Next, Petitioner's primary care doctor referred him to Scott Glaser, a pain management doctor. This treatment was paid by Petitioner's group health insurance, an HMO through his work, which requires referrals to see a specialist. Dr. Glaser gave Petitioner injections, and also ordered physical therapy. However, Petitioner has not been able to do the physical therapy because it is not covered by his group health insurance.

Prior to the accident in this case on June 27, 2017, Petitioner had some problems with his back while working for Respondent. Each time, Petitioner saw the company doctor, got some pain meds, and returned to work full duty the next day. He also had treatment by his PCP and Chiropractor Astroth (PX I, RX J)

Petitioner testified that at the time of the accident, he was making about $35 per hour, with frequent overtime, which was mandatory. Petitioner would get written up if he refused overtime. On one occasion, he worked about 30 hours straight. His work, installation of furnaces and air conditioners, was seasonal. Winter and summer are extremely busy, but in between those times, he often only worked once or twice a week. Obviously, a furnace/air conditioner installation has to be completed once it is started, so an installer has to stay on the job until it is completed.

Petitioner has currently been working light duty as a parts clerk for Respondent, continuously since he first got medical attention (and work restrictions were given) by Concentra on June 30, 2017. At the time of the hearing, Petitioner was getting paid $20.86 per hour in the parts clerk position. Petitioner's primary job duties as a parts clerk include replenishing parts on the trucks used by service techs and going on the computer and warrantying the parts that the service techs bring back.

John Coggins testified at the request of Respondent. He is employed by Four Seasons as a Director of Warehouse Operations and has worked for Respondent for 17 years. Coggins is Petitioner's supervisor in the parts department. There are two divisions of the parts department: 1) the inventory and warranty department, and 2) the internal side. The inventory and warranty department employees restock and maintain inventory on the service vans, and also process equipment and part warranties. The employees on the internal side order parts and provide technical support to the service techs. Petitioner works in a permanent position in the inventory and warranty department.

Mr. Coggins said that Petitioner's work is "above average," and that his experience in the field is invaluable, and that he is "next in line" to move to the internal and technical support side. Coggins testified that the internal/technical position is "high stress," and, when offered, many employees decline to move to the internal side. The pay scale for internal side -technical support workers starts at $15.80, and the most senior person in the internal room, who has been in that division since about 2005, makes about $22-23 per hour.

Mr. Coggins also testified that three other people work with Petitioner in his division in parts, Ivan Mena, Jarrod Wilson and Julio Gaza. They all have the same job title, job duties, and job description. Mr. Coggins could not name any job duty that Petitioner performed that any of the other three did not. Ivan Mena, makes about $15 per hour, Julio Gaza makes about $16-17 per hour, and Jarrod Wilson makes about $18 per hour. There was no testimony regarding these employees' field experience.

Darius Pietura testified at the request of Respondent. He is the Director of Human Resources at Four Seasons and has worked for Respondent for three years and eight months. Pietura testified that Petitioner's current position in parts is a full time, 40 hours per week, a position that is permanent.

Mr. Pietura explained that when Petitioner was working as an installer, his compensation was performance based, and he was paid by the piece. Thus, Petitioner was paid the same rate no matter if he works 10 hours or 60 hours in a week. Petitioner got paid an hourly rate for warranty work.

Medical Records:

On July 30, 2017, Petitioner presented to Concentra Medical Center. (PX A) Petitioner reported a work accident from June 27, 2017, which occurred while he was lifting a compressor. Petitioner complained of low back pain and lateral thigh numbness and described an increase in symptoms over the course of the day following the work-accident. The physical examination revealed a positive straight leg raise test. Petitioner was diagnosed with a lumbar strain and prescribed naprosyn, physical therapy, and Flexeril. He was placed on light duty work restrictions of no lifting greater than ten pounds. (PX A)

On July 5, 3017, Petitioner began physical therapy at Concentra, and underwent four sessions of therapy before a return to his physician on July 17, 2017. He complained of ongoing right-sided low back pain radiating into his right thigh, which he described as sharp and shooting in nature. Tenderness was noted at the L5 level. Petitioner was to continue with additional therapy. On July 24, 2017, Petitioner returned to Concentra, complaining of radiating low back pain. The diagnosis now included lumbar radiculitis, and he was referred for a lumbar spine MRI. Petitioner was to continue with light duty work restrictions, now of no lifting greater than twenty pounds. Physical therapy was continued. (PX A)

On August 3, 2017, Petitioner underwent a lumbar spine MRI at Chicago Ridge Medical Imaging. The radiologist reported a central posterior annular tear at L4-L5, and bilateral neural foraminal stenosis at L4-L5, with the left side worse than right, compressing the exiting nerve root. (PX D)

On August 7, 2017, Petitioner presented to Dr. Sajjad Murtaza through Concentra. (PX A) Petitioner provided a consistent history of accident and pain complaints. Dr. Murtaza reviewed the lumbar spine MRI and agreed with the radiologist, insofar as Petitioner had a L4-L5 annular tear and bilateral foraminal stenosis. Dr. Murtaza diagnosed Petitioner with discogenic pain and radicular symptoms and prescribed a Medrol Dosepak and a bilateral transforaminal epidural steroid injection at L4-L5. (PX A) The injection was re-prescribed on September 11, 2017. (PX A, PX G)

On September 21, 2017, Petitioner received a transforaminal epidural steroid injection at L4-L5 by Dr. Sajjad Murtaza at Illinois Orthopedic Network. (PX G)

On October 9, 2017, Petitioner returned to Dr. Murtaza, complaining of low back radiating into his bilateral lower extremities. Dr. Murtaza referred Petitioner for a neurosurgical evaluation with Dr. Sean Salehi. Dr. Murtaza also opined that Petitioner should remain under light duty work restrictions of no lifting more than twenty pounds, no bending more than six times per hour, no pushing/pulling greater than thirty pounds, and limited kneeling, sitting, and standing. (PX A)

On November 15, 2017, Petitioner sought treatment with his primary care physician at Soumya Health, complaining of sharp pain in his lower back, radiating to his bilateral lower extremities. (PX B) Petitioner was prescribed Norco. Petitioner returned to Soumya Health for a renewal of pain medications on several occasions, including December 11, 2017, March 28, 2018, and May 7, 2018. In 2018, Petitioner was referred for a neurosurgery evaluation with Dr. DiGianfilippo and a pain management consultation by Dr. Khan. (PX B)

On November 17, 2017, Petitioner underwent a neurosurgery evaluation with Dr. Sean Salehi on referral from Dr. Murtaza. (PX A) Petitioner was complaining of low back pain, radiating into his bilateral lower extremities, which he reported did not improve with physical therapy or steroid injections. Physical examination revealed lumbar tenderness and a positive left sided sciatic notch test. Dr. Salehi opined Petitioner suffered from lumbar disc disease. Petitioner was not a surgical candidate. Dr. Salehi prescribed a functional capacity evaluation and continued light duty work restrictions. Petitioner then underwent the Functional Capacity Evaluation, as prescribed, through Concentra on December 5, 2017. (PX A)

On December 8, 2017, Petitioner returned to Dr. Salehi for a review of the functional capacity evaluation. The evaluation revealed the testing was valid, as Petitioner provided consistent effort. The evaluation placed Petitioner at medium duty work restrictions. Dr. Salehi agreed with the results of the FCE and opined Petitioner had permanent restrictions consistent with the FCE. Petitioner was released from care, to return on an as-needed basis. (PX A)

On January 22, 2018, Petitioner underwent a second opinion neurosurgery evaluation with Dr. DiGianfilippo on referral from Petitioner's primary care physician. (PX E) Petitioner complained of low back pain, radiating into his hips and also reported the low back pain was radiating up into his thoracic spine. Dr. DiGianfilippo diagnosed Petitioner with a L4-L5 and L5-S1 disc bulge. Petitioner was referred for a thoracic spine MRI. On February 2, 2018, Petitioner underwent the thoracic spine MRI at Chicago Ridge Medical Imaging. The examination did show degenerative findings with thoracic disc protrusions of indeterminate age at several levels. (PX D)

On March 5, 2018, Petitioner returned to Dr. DiGianfilippo. (PX E.) Dr. DiGianfilippo diagnosed Petitioner with low back and thoracic spine pain, and opined Petitioner did have permanent restrictions. Dr. DiGianfilippo opined Petitioner was not a surgery candidate. Petitioner reported he was continuing to work in a light duty capacity for Respondent. (PX E)

On May 12, 2018, Petitioner underwent a pain management evaluation with Dr. Khan of Modern Pain Consultants. (PX F) Petitioner gave a consistent history of accident and ongoing lumbar spine pain with radiating symptoms. Dr. Khan opined Petitioner's condition was causally connected to his work-accident. Dr. Khan opined Petitioner was suffering from lumbar disc displacement, a lumbar spine annular tear, lumbar foraminal stenosis, spinal stenosis, and lumbago. Dr. Khan recommended a discogram, which Petitioner declined.

Over the next six months, Petitioner continued to seek treatment with his primary care physician and received renewals of his Norco prescription. (PX B)

On June 26, 2018, Petitioner underwent a Section 12 Independent Medical Examination with Dr. Kenneth Candido. (RX E) Dr. Candido reviewed records through the April 12, 2018 treatment by Dr. Farooq Kahn. Dr. Candido opined Petitioner sustained an exacerbation of his lumbar spine condition and possible new onset of disc disruption due to the June 27, 2017 work-accident. Dr. Candido agreed the work accident caused and contributed to the Petitioner's complaints. Dr. Candido opined Petitioner was at MMI, and he agreed with the restrictions detailed in the FCE. Dr. Candido's diagnosis was: Lumbar spondylosis, chronic; Internal disc disruption, chronic; and Lumbar pain, resolved. Petitioner no longer has signs of lumbar radiculopathy and his pain levels were very low and moderate. Treatment to date was reasonable and necessary. Petitioner's complaints had resolved with conservative treatment and interventional medicine. There was no permanent disability as a result of the injury.(RX E)

On November 21, 2018, Petitioner underwent a second opinion pain management evaluation at Pain Specialist of Greater Chicago, with Scott Glaser, M.D. (who also billed/treated out of Hinsdale Surgical Center (PX H; PX L) Dr. Glaser diagnosed Petitioner with facet syndrome of the thoracic spine, and facet syndrome of the lumbar spine, without myelopathy. (PX H; PX L) Dr. Glaser prescribed bilateral facet joint injections to multiple levels, L3-S1. Petitioner underwent the first course of injections on December 11, 2018, and the second course of injections (at the T12-L1, L1-L2 and L2-L3 levels) on January 23, 2019. (PX H) On February 12, 2019, Petitioner returned to Dr. Glaser for a re-evaluation and was prescribed physical therapy. (PX H; PX L) Petitioner did not undergo physical therapy, as the treatment was denied by Respondent and his group insurance. Petitioner testified that he desires the treatment prescribed by Dr. Glaser.

Wage records were submitted by both Parties. PX J was Petitioner's wage records. PX K was parts department wage rates and job description. RX B was a wage statement for Petitioner. RX G was parts department hourly employee wages. Rx K was Petitioner's W-2 statements for 2018 ($30,856.42 wages), 2017 ($25,108.22 wages) and 2016 ($29,657.99 wages).

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)).

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

ISSUE (C): Did an Accident Occur That Arose Out Of and In The Course of Petitioner's Employment by Respondent and ISSUE (D): What Was the Date of the Accident?

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 27, 2017.

This finding is based on the testimony of Petitioner and the medical records.

ISSUE (E): Was Timely Notice of the Accident Given to Respondent?

Petitioner gave timely notice of the accident to Respondent, in accordance with §6 of the Act.

This finding is based on the testimony of Petitioner, which was unrebutted as to this issue. On June 30, 2017, Petitioner told his supervisor, Mike Cirar, that his back was hurting and Cirar told Petitioner "to go to the clinic right away." Petitioner then went to Concentra, Respondent's clinic, where the examination was consistent with a back injury and Petitioner was released to restricted duty, which Respondent has accommodated up to the date of trial. Further, RX D shows that Respondent's WC carrier paid the Concentra bill for the June 30, 2017 date of service on July 21, 2017, well within the 45 days required by §6. If PMA didn't know about the accident, how could it have properly paid the bill?

ISSUE (F): Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury?

The Arbitrator finds that as a result of the work-accident on June 27, 2017, Petitioner sustained an aggravation of his pre-existing low back condition resulting in displacement of the disc at L4-L5 with radiculitis, low back pain and myalgia, with eventual permanent work restrictions per the FCE of December 5, 2017.

This finding is based on the Arbitrator's findings above regarding Accident, the testimony of Petitioner, the medical records and the report of Dr. Candido. The Record does not persuade the Arbitrator that any condition of ill-being regarding Petitioner's thoracic spine is causally related to the injury. There are no findings regarding the thoracic spine until Petitioner was seen by Dr. DiGianfillippo in January of 2018. This is to remote from the accident date.

ISSUE (G): What Were Petitioner's Earnings?

On the date of the accident, Petitioner worked as an HVAC lead installer. This work was seasonal. Overtime was mandatory. Petitioner explained that he typically only worked a few days a week between the busy summer months installing air conditioners and winter months installing furnaces. Petitioner claimed an AWW of $1,298.72. Respondent claimed that the AWW was $790.36. (ArbX 1)

The Arbitrator finds that Petitioner's Average Weekly Wage was $854.61.

The Arbitrator made this finding by adding Petitioner's gross pay from the pay period of 6/9/2016-6/22/2016 to the period of 6/8/2017-6/21/2017 (the last full pay period immediately preceding the date of accident) and dividing by 52. The Arbitrator believes that this best comports with the requirements of §10. Due to the nature of Petitioner's earnings as a lead installer (piecework, hourly pay, overtime pay) the testimony and wage and earnings records adduced do not persuade the Arbitrator that a calculation pursuant to Sylvester v. Industrial Comm., 197 Ill.2d 225 (2001) and Edward Don Co. v. Industrial Comm'n, 344 Ill. App. 3d 643 (2003) can be made.

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 findings above regarding accident and causal connection and the opinion of Dr. Candido that the treatment rendered to date (June 26, 2018) has been reasonable and necessary, the

Arbitrator finds that Petitioner's claim for expenses related to treatment rendered to Petitioner through the Dr. Candido IME date is appropriate and should be awarded.

A blanket award of "payment of all medical expenses". etc. is interlocutory and not enforceable beyond the Commission level. See: Consolidated Freightways v. Illinois Workers' Compensation Comm'n, 373 Ill. App. 3d 1077 (2007) The Arbitrator declines to make such an award.

Petitioner submitted records and bills from nine providers. (PX A; B; C; D; E F G; H and L) Respondent submitted its carrier's payment log (RX D) and information from BCBS regarding a claimed §8(j) credit.

Several of the bills submitted by Petitioner have zero balances and no award is made for them. The following exhibits/bills are in that category: Ex. A – Concentra; Ex. C – Metropolitan Institute of Pain (Dr. Murtaza); Ex. D-Chicago Ridge Medical Imaging; Ex. E – Amita (Dr. DiGianfillippo); Ex. G – Illinois Orthopedic Network and Midwest Pharmacy; Ex. H – Pain Specialists of Greater Chicago; Ex. L – Hinsdale Surgical Center.

The following bills from Soumya (PX B) are awarded: 3/23/18 - **$229.83** (Work Man Comp. – low back complaints; 12/11/17 - **$30.00** (Severe low back pain, referral to Dr. DiGianfillippo). Bills for 5/7/18 and 8/13/2018 ($229.93, $25.00, $30.00) are denied, as the treatment was for urology issues.

The bill from Dr. Farooq Kahn, Modern Pain Consultants (DOS: 4/12/18 - **$610.00**) is awarded.

The total amount of medical expenses awarded is: $869.93. The award is pursuant to §§8(a) and 8.2 of the Act and Respondent is entitled to a credit for all awarded bills that it has paid or satisfied.

As the Arbitrator makes an award for PPD in this case, Petitioner's claim for prospective medical treatment is denied.

ISSUE (K): What Temporary Benefits Are in Dispute? TPD

Based upon the Arbitrator's finding on the issue of AWW, above, Petitioner's claim for TPD is denied.

ISSUE (L): What Is the Nature and Extent of the Injury?

Petitioner sought an award pursuant to §8(d)1 of the Act. Based upon the Arbitrator's finding regarding the issue of AWW above and the evidence adduced, Petitioner has failed to prove entitlement to a wage loss claim. Petitioner has proved that he is partially incapacitated from pursuing his usual and customary line of

employment but the proofs do not support a finding that there is a difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident (HVAC lead installer) and the average amount which he is earning or is able to earn in some suitable employment or business after the accident (inventory/warranty parts clerk).

The Arbitrator believes that an award for permanent partial disability pursuant to §8(d)2 is appropriate In this case.

An AMA impairment rating was not done in this matter; however, Section 8.1(b) of the Act requires 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 examined." 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 partial permanent disability. This factor is given no weight in determining PPD.

2. Petitioner's Occupation

On the date of the accident, Petitioner was a HVAC lead installer, a very physically demanding job for which he received extensive training and had substantial experience. He was not able to return to work to his usual and customary position as a result of the injuries sustained. This factor is given great weight in determining PPD.

3. Petitioner's age at the time of injury

Petitioner was 33 years old at the time of injury, Petitioner is still young and he will have a long work life ahead of him which will be limited by the permanent work restrictions that resulted from the injury. This is relevant and should is given moderate weight in determining PPD.

4. Petitioner's future earning capacity

Petitioner a slight loss of earnings at present because Respondent has accommodated his work restrictions in The parts clerk job at a similar AWW. The skills developed in the new job and his prior experience as a HVAC lead installer do seem to provide Petitioner with a stable job market. This factor is given moderate weight in

determining PPD.

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

As a result of the work injury, Petitioner sustained an aggravation of his pre-existing low back condition resulting in displacement of the disc at L4-L5 with radiculitis, low back pain and myalgia, with eventual permanent work restrictions per the FCE of December 5, 2017. The medical records support a finding that Petitioner is entitled to an award of permanency. This factor is given great weight in determining PPD.

After considering all of the above factors, and all of the evidence adduced, the Arbitrator finds that, as a result of the injuries sustained, Petitioner suffered the 20% loss of use of the person as a whole, in accordance with Section 8(d)2 of the Act.

ISSUE (M): Should Penalties or Fees Be Imposed upon Respondent?

Petitioner's claim for penalties and fees is denied. Petitioner's entitlement to TPD benefits is disputed in good faith, given the Arbitrator's finding on the issue of AWW and the denial of TPD and §8(d)1 benefits.

Respondent's dispute on the issue of Accident is weak, but it cannot be said to be in bad faith. Its dispute on the issue of Notice cannot be said to be in good faith, as it sent Petitioner to the company clinic 3 days after the date of accident and its carrier paid the bill some 4 weeks after the accident date. The Commission is urged to consider penalties due to a frivolous defense.

ISSUE (N): Is Respondent due any Credit?

Respondent is entitled to a credit for the medical bills that it has paid or satisfied.

Respondent claimed a §8(j) credit for Blue Cross Blue Shield payments and supported it with RX I. The Injection procedure of 1/23/2019 to levels of the thoracic spine and upper lumbar spine is found to be not causally related to the injury. Therefore, no §8(j) credit applies. As to the Hinsdale Surgical Center bill from the procedure of 12/11/2018, the request for §8(j) credit is allowed, but only to the extent of amounts so paid by Blue Cross, as is allowed in the Act.

ISSUE (O): Other Issue: Choice of Provider/Chain of Referral

Regarding the two choice rule, the Arbitrator finds Petitioner did not exceed the number of choices of providers allowed under §8(a) of the Act.

Petitioner initially treated with the Respondent's company clinic, Concentra, which is not one of Petitioner's choices. Petitioner was directed to seek treatment there by his supervisor, Mr. Cirar. Through Concentra, Petitioner treated with Dr. Sajjad Murtaza, and was referred by Dr. Murtaza to Dr. Sean Salehi, Chicago Ridge MRI. Petitioner's first choice of physician was his primary care facility, Soumya Health. From Soumya Health, Petitioner was referred to Dr. DiGianfilippo and Dr. Khan. While Petitioner did seek further treatment from Dr. Glaser, he utilized his HMO health plan due to the denial of treatment from Respondent. He returned to his primary care physician (Soumya) and received a referral for pain management treatment, which he then utilized to see Dr. Glaser. This is at most Petitioner's second choice and, arguably remains in the first chain of referrals.

Petitioner did not violate the two-choice rule.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC038988
Case Name	DUNLEVY, JOSEPH M v. ARCH COAL INC
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	21IWCC0407
Number of Pages of Decision	21
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	James Ackerman
Respondent Attorney	Robert Hoffman

DATE FILED: 8/9/2021

/s/ Kathryn Doerries, Commissioner

Signature

21IWCC0407

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH DUNLEVY,

Petitioner,

vs. NO: 15 WC 38988

ARCH COAL, INC.,

Respondent.

DECISION AND OPINION ON PETITIONER'S PETITION UNDER §19(h) and §8(a)

This matter comes before the Commission on Petitioner's Petition for Review under §19(h) and §8(a) of the Act, filed on November 6, 2017, alleging a material increase in his disability since the Commission's previous Decision and Opinion on Review in case number 17 IWCC 0665, dated October 20, 2017, modifying the Arbitration Decision and reducing the award of loss of use of Petitioner's left great toe from 90% to 50% under §8(e), and affirming all else. A hearing on the §19(h) and §8(a) petition was held before Commissioner Kathryn A. Doerries on October 27, 2020, with both parties represented by counsel and a record was made. The Commission, having considered the entire record, finds that Petitioner failed to prove a material increase in disability and that as a result Petitioner's §19(h) and §8(a) Petition is denied, for the reasons set forth below.

Section 19(h)

> The purpose of a proceeding under §19(h) is to determine if a petitioner's disability has "recurred, increased, diminished or ended" since the time of the original decision of the Industrial Commission. (Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h); *Howard v. Industrial Comm'n* (1982), 89 Ill. 2d 428, 433 N.E.2d 657.) To warrant a change in benefits, the change in a petitioner's disability must be material. (*United States Steel Corp. v. Industrial Comm'n* (1985), 133 Ill. App. 3d 811, 478 N.E.2d 1108.) In reviewing a §19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed

> materially since the time of the Industrial Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.)

Gay v. Industrial Comm'n, 178 Ill. App. 3d 129, 132, 532 N.E.2d 1149, 1151, 1989 Ill. App. LEXIS 3, *5-6, 127 Ill. Dec. 320, 322.

Gay is otherwise instructive regarding the analysis of a §19(h) material change. In *Gay*, the Petitioner underwent a total left knee replacement, however, the Court held surgery alone was not a basis, in and of itself, to find there was a material change in the Petitioner's condition. The *Gay* Court addressed Petitioner's evidence that she had a total left knee replacement, still suffered pain in her left knee, her hips, her lower back and her diagnosis of post-traumatic arthritis of her left knee, and held the following:

> From this evidence, we find that petitioner failed to present evidence of a substantial difference between her pre- and post-surgery disability. Petitioner still had a limited range of motion in her left knee, she still had pain, she still used a cane for ambulation, and she continued to take medication. These same symptoms of petitioner's disability were apparent at her original hearing before the Industrial Commission, and the diagnosis of her disability was substantially the same at the §19(h) petition hearing as at the original hearing before the Industrial Commission. Petitioner urges this court to conclude that the replacement of a natural part with a prothesis alone is sufficient to show a material increase in a petitioner's disability. There is no mechanical test for determining whether the Commission should measure a disability with or without a corrective prosthesis. (*Gilbert & Shughart Painting Contractors v. Industrial Comm'n* (1985), 136 Ill. App. 3d 163, 483 N.E.2d 392; *Motor Wheel Corp. v. Industrial Comm'n* (1979), 75 Ill. 2d 230, 388 N.E.2d 380 (measure of damages is between uncorrected vision at time of accident and uncorrected vision thereafter); see also 2 A. Larsen, The Law of Workmen's Compensation § 58.13(f) (1987) (similar questions may arise as to prosthetic devices other than eyeglasses)) This is because neither the "uncorrected impairment" rule nor the "corrected impairment" rule adequately covers all cases. (*Motor Wheel Corp*., 75 Ill. 2d 230, 388 N.E.2d 380, citing *Lambert v. Industrial Comm'n* (1952), 411 Ill. 593, 104 N.E.2d 783.) How correctability should be weighed is a factual question. (*Walker v. Industrial Comm'n* (1978), 72 Ill. 2d 408, 381 N.E.2d 238) In this case, the Industrial Commission made the factual determination that petitioner's prosthesis did not materially increase her disability. Further, we find that the Industrial Commission's decision of a 50% left leg disability took into consideration the future need for a total knee replacement for a progressive condition. Thus, the Industrial Commission's decision that petitioner had no material increase in her disability was not against the manifest weight of the evidence.

Gay v. Industrial Comm'n, 178 Ill. App. 3d 129, 132-134, 532 N.E.2d 1149, 1151-1152.

Further, the Appellate Court has held that "the question of material change should precede the question of causation." *Miller v. Ill. Workers' Comp. Comm'n*, 2020 Ill. App.

Unpub. LEXIS 124, *19-20, 2020 IL App (2d) 218577WC-U, P57. Thus, we will first analyze whether there has been a material change in Petitioner's condition; if affirmative, we will analyze whether or not the Petitioner's condition of ill-being that caused the material change is causally related to his work accident.

Background

Arbitrator's Hearing and Decision

Petitioner was injured when a large stone/shale piece, estimated to weigh between 400-600 pounds landed on his left leg causing a displaced spiral fracture of his distal tibia and a comminuted displaced obliquely oriented fracture of the proximal fibula and a non-displaced malleolus fracture. He had a previous left metatarsal fracture in 2013. Petitioner underwent surgery on September 1, 2014, which repaired the left posterior malleolus and reduced and nailed the left tibia (intra-medullary nailing). A nail was inserted down the tibia. Petitioner described it as a nail going from his knee to his ankle. He was in patient through September 4, 2014. (AD p. 1)

By October 14, 2014, Pet saw his surgeon because he could not extend his left great toe. The surgeon thought the tendon in the toe might be bound by the terminal screw and it might have ruptured. Petitioner was taken off work in light of his many problems including panic attacks. (PX3) Eventually he underwent a left great toe tenodesis of the EHL on March 9, 2015, in which the Petitioner's left toe tendon was sewed to the bone. (PX3) On July 26, 2015, the hardware was removed from Petitioner's left knee because of ongoing pain complaints. (PX3) Petitioner underwent physical therapy from July 20, 2015 through August 20, 2015. As of July 20, 2015, Petitioner reported he had no complaints of pain. One week later he returned to physical therapy to report his knee was feeling fairly well until his truck was hit from behind. Since then his knee felt like it needed to pop and his ankle had swelled. (AD. p. 6)

By July 31, 2015, Petitioner was feeling pretty good. The therapist noted some instability and proprioception exceptive deficit, which the therapist hoped would improve with weight bearing and exercise. On August 7, 2015, Petitioner reported his knee felt the best it had since accident with no real pain, just some pressure. The therapist noted he had no feeling in the ball of the foot, aggravating his poor proprioception. On August 10, 2015, the therapist noted he had decreased balance with activities but, otherwise, his knee and ankle felt pretty good. (PX3) By August 11, 2015, Petitioner felt like he was doing much better and wanted to return to work full duty. He was given a release to return to work as of August 17, 2015. Dr. Wolters noted he was not having swelling, locking or catching. He had no difficulty walking, running, or squatting. Petitioner had full range of motion of his left knee. He lacked any tenderness along the patellar tendon. Dr. Wolters recommended controlled physical therapy and conservative management anticipating MMI in two months. (PX3)

On August 14, 2015, at physical therapy, Petitioner said he had instances of his nerves "trying to fire" through his legs. He was excited to return to work on Monday and would be undergoing a physical exam test prior to returning to work. He was discharged from therapy. On October 9, 2015, Dr. Wolters met with Petitioner and noted he was doing quite well. He advised Petitioner to continue his HEP. Petitioner was at MMI and noted he had worked 70 hours a week

without discomfort or swelling although reported he would get a little sore on occasion. He was not taking any pain medication. His alignment was in "slight valgus " but Dr. Wolters didn't believe it could cause any "significant issues" with arthritis in the future. Dr. Wolters felt the risk of continued patellar tendon pain in anterior knee pain was small. Petitioner was released at MMI. (PX3; RX1)

At the Arbitration hearing, Petitioner testified that he was 27 years old at the time of trial. He further testified that he graduated from Williamsville High School and attended some classes at Lincoln Land Community College, but he doesn't have a college degree. Petitioner has worked for the coal mine ever since he went to Lincoln Land Community College, about eight years.

Petitioner is a production roof bolter for Respondent at its coal mine. He puts roof bolts in the roof of the mine with steel rebar to protect workers. He is required to stand on his feet for eight hours in this position with no sitting.

Petitioner testified that he occasionally has to clean and shovel the belts. In this capacity, he shovels the belts to get the coal off of them. On an average night, they lift 350 eight foot roof bolts. They are each about ten pounds that have to be lifted about eight feet high, so you have to bend the piece of metal and then shove it up on the top and straighten it out with your arms. Petitioner does a lot of lifting of relatively small weights. Occasionally, he has to lift heavier weights. The maximum lifting he has to do is ninety pounds in certain circumstances.

Petitioner also testified that he has worked in a ram car while on light duty. According to Petitioner, this job requires that the miner load a ram car full of coal and then take it to a belt. The ram car then dumps it on a belt. Petitioner described it as being like a dump truck underground. It is a sit down job.

Petitioner testified that he never had any problems with his right arm, left leg, left ankle, or big toe prior to his accident.

Petitioner testified that, as a result of the accident, a drill landed on his right arm and caused a burn (see photos). Petitioner testified that he doesn't have any pain in his arm, only a very small scar which the Arbitrator viewed and noted was not even the size of a dime.

Petitioner testified that his left ankle gets pretty stiff and pops a lot. Petitioner spends a lot of time working it back and forth making sure it does not stiffen up. He does an exercise which is similar to a brake pedal/gas pedal type of thing where he does flexion extension. This gets it loosened up. Petitioner testified that he does this every day when he gets up in the morning. He tries to get up three to four hours (AD p. 8) before he goes to work to get his leg functioning so that he can use it correctly. He does the exercises for an hour. He does a rolling motion which helps a lot. When he does the rolling motion with his ankle, he has a popping sound like one hears when popping a knuckle. Petitioner explained that if he doesn't do this, he has a bad limp in his ankle.

Petitioner also testified that his ankle bothers him when it rains and his ankle will swell about one and a half times the normal size and is very tight. Sometimes he feels a loss of range of

motion. Petitioner testified that his ankle is always swollen when he wakes up in the morning and if he can keep working it, keep it elevated and put ice on it, it will bring the swelling down. Petitioner testified to a lack of feeling in the front part of his shin. According to Petitioner, it goes, basically, from the top of his knee to right above his ankle, and it goes all around the front part of his shin. Petitioner is concerned he will start having significant pain in it if he ever gets the feeling back.

With regard to his left leg, Petitioner testified that he normally gets in the hot tub, depending on the weather, and he sits in it for an hour and a half while he tries to move his leg back and forth. The warm water helps it if he can get it hot enough. He likes to have the massaging jets on it when he is in the hot tub in the morning. Petitioner also testified that he gets up and walks around to limber his leg up. If he does not limber it up as described, he feels weak and he will lose a lot of range of motion. Petitioner explained that in his job, he has to be able to turn and cut very often and very quickly to get out of the way of things that are happening in the mine. His job also requires him to do a lot of turning and twisting when performing the roof bolting, so he needs significant range of motion. If he is not able to plant and turn his knee will buckle. If he does not use his leg to get it moving, he feels shaky in his leg. Petitioner testified that his leg will not hold up the way that he needs for it to hold up.

Petitioner testified that he is able to walk about a quarter mile above ground. He can do that when he is out on the weekends. As long as he has a place to sit down, he can stand the whole day and walk around if there is a festival or something. However, he has to be able to sit every thirty minutes or so, because he has swelling and he starts limping badly. (AD p. 9)

When asked why he went back to work, Petitioner explained that he saw a lot of people take extended time off for injuries that were not hurt very badly. He considered it as a “pride thing." Petitioner stated he saw a lot of people work the system with minimal injuries and he did not want to do that. Petitioner further testified that he had difficulty working in the ram car because one is not allowed to have one's body out of the piece of equipment, so he has to sit down the whole time, which causes his leg to cramp. Petitioner testified that his leg is always swelling and causes a lot of pain. Petitioner also testified that when he is inside the small cabin, he is unable to work his leg and get it moving, so it started getting worse and worse. Petitioner testified that he “begged and pleaded" with his employer, so they finally let him rake and shovel belts. He further testified that when he started doing that, it started feeling a little better. Petitioner testified that he is currently back to roof bolting. When asked what he would do if he could no longer do his job, Petitioner testified that he did not know. He indicated that he has been doing the roof bolting job since he was twenty and he is now twenty seven years old. Petitioner testified that his range of motion in his knee is reduced. Petitioner also testified that when he gets home from work, he gets cleaned up and goes into the hot tub or the tub. He explained that by that point in the day, it is usually swollen. In the car ride home, it freezes up and swells once he gets off of it. He usually spends two and a half or three hours in the tub trying to get it to stop throbbing or just loosen it up enough so that he can go to sleep without it bothering him. Petitioner testified that elevation helps his leg so he spends a lot of time in his recliner with his leg elevated. If he stays off of his leg too long, it stiffens up.

Petitioner testified that his big toe has no range of motion in it. When he went to Dr.

Wottowa (Wolters) after the injury, Dr. Wolters noticed that the nerve test showed there was no nerve function in the big toe. Dr. Wolters decided that he would pin the big toe so that it would not bend down, which would cause it to catch on things. Petitioner testified that he would catch his big toe on things and could not figure out why it was catching. (AD pp. 10-11) He was using a walker at the time and keeping his foot up. However, he could feel it dragging every once in a while. Petitioner testified that he has no range of motion in his big toe because it is surgically pinned. It just sticks straight out and he cannot move it. It cramps if he has a shoe on. He is concerned that his muscle will pull the big toe and then break the tendon. He acknowledges that is probably far-fetched, but he worries about it. Petitioner testified that his toe cramps about three to four times a week.

Petitioner testified that on a good day he does his ritual, goes to work, comes home, has minor swelling, and not a lot of pain. He describes it achy more than anything. On a bad day, his leg swells up badly as soon as he gets home and he has to get off of it. Some days his leg swells so badly it makes him sick to his stomach. Petitioner testified that he walks with a bad limp on bad days but, on a good day, it's not too bad.

Petitioner testified that he takes Tylenol for pain which he described as an achy and dull pain "24/7."

When asked to describe how his injury affects his job, Petitioner testified that his pace is reduced because of the leg injury. Normally, he is required to work at a fast pace and push himself hard and he can only leave so many places swinging unsupported for the next shift, so he is supposed to hurry and be quick; however, he finds it hard to keep up with everyone else because of his leg. Petitioner acknowledged that he was released on August 17, 2015, to light duty. He has worked for Arch Coal since then. When he was initially released, he went back to driving the ram car, which he did for a couple of weeks. Then he began shoveling for about a month or two. He was back to roof bolting in October 2015.

Petitioner testified that he went back to the doctor on August 4, 2016, for a check-up on his knee. No additional surgery has been prescribed.

Kenneth Dunlevy, Petitioner's father, testified Petitioner lives with him and they see each other every day. Mr. Dunlevy takes Petitioner to work sometimes, depending on the shift. (AD, p. 11)

Mr. Dunlevy describes that Petitioner is in pain all the time now as noted by his facial expressions and the fact that he will moan when he is walking. Petitioner is constantly in the bathtub before work and after work. Mr. Dunlevy described it as "a ritual". Mr. Dunlevy testified that his son is no longer the same person. He is totally different from the way he was prior to the injury. According to Mr. Dunlevy, Petitioner limps and it looks like his leg will kick out from him from time to time. When he picks his son up from work, Mr. Dunlevy watches him walk from his work for about thirty to forty yards, noticing that he limps the whole way to the truck. He further testified that Petitioner limps on the way to work, but not as badly.

Mr. Dunlevy testified that Petitioner's moods have changed and he now has horrible

moods. He is always mad. If you try to help him out, he will "bite at you." Mr. Dunlevy testified that he used to have a great relationship with his son and his mother did too. Mr. Dunlevy feels that his son's change in mood is related to his pain. Mr. Dunlevy stated that you can physically see him in pain. Mr. Dunlevy testified they have two living rooms in the house. In the front living room, they set up a specific recliner so that if Petitioner is not at work or in the bathtub, he can sit in the recliner because he likes to elevate his leg. Mr. Dunlevy testified that Petitioner sits in the tub for an hour to three hours at a time. (AD. p. 12)

The Arbitrator concluded that Petitioner's current condition of ill-being in his left leg, left knee, left ankle and left great toe are causally connected to his undisputed accident. This was based upon Petitioner's very credible testimony, the opinions of Petitioner's treating physicians, the medical records, and a chain of events. Petitioner never had any problems before the accident. (AD. p. 12)

In the Arbitration Decision filed October 27, 2016, the Arbitrator found that Petitioner was entitled to permanent partial disability benefits of $542.75/week for 130.95 weeks, because the injuries sustained caused the 45% loss of use of the Petitioner's left leg (96.75 weeks) and 90% loss of use of Petitioner's left great toe (34.2 weeks), as provided in § 8(e) of the Act. (Arb.Dec. p.2) On October 20, 2017, the Commission affirmed and adopted the Arbitrator's Decision in its entirety, except finding that Petitioner embellished the extent of the injury to his left great toe when testifying before the Arbitrator on August 25, 2016, and, as a result, found the injury to Petitioner's left great toe resulted in the 50% loss of use of that toe. (10/20/17 C. hearing, PX2)

Petitioner timely filed a §19(h) and §8(a) Petition on November 6, 2017. Commissioner Doerries presided over the §19(h) and §8(a) hearing on October 27, 2020. Petitioner's motion for extension of time to file a brief was granted on November 18, 2020. Petitioner filed timely briefs and Respondent filed a brief on February 25, 2021.

§19(h) and §8(a) Commission hearing

At the §19(h) and §8(a) Commission hearing on October 27, 2020, the Petitioner testified as follows:

Since the first trial he started developing a really bad pain in his hip. He talked to his coordinator at the time Gabe Alderman. That went on for a few days, then he went to Jason Stockton one morning before he went underground. He was on day shift, and he told Jason Stockton he could not do it anymore; he needed to go talk to Jeanine or Ralph Hill "about the situation." He then started therapy. He tried injections next, and then went to MOHA for a different type of physical therapy. Petitioner thought that caused more pain, so he stopped that. He had an MRI that Petitioner thought was not clear enough for his doctor to make a diagnosis. Then he had an arthrogram and that's when it showed "the damage to the inside of the hip." (10/27/20 T. 10-11; 21-22)

That MRI was August 18, 2017. He had a performance test at Memorial on October 17, 2017; then he had a second MRI arthrogram on August 24, 2018. Dr. Wolters did surgery on him and he participated in an FCE. (10/27/20 T. 11-12)

After August 11, 2017, Petitioner noticed " a really strong pain in my back and it was to the left side lower, and then it developed into his groin. The pain in the groin was predominantly when he was sitting down. (10/27/20 T. 20)

Petitioner did not perform above ground work after August 11, 2017, through September 14, 2017. He was off from September 14, 2017 through his surgery. He had performed a physical agility test on September 14, 2017, to see if he was able to get back underground. He had to pass certain physical requirements to go back underground. The test consisted of a push/pull test, climbing a ladder up and down, stairs, walking a 2 x 4 for balance, pushing a cart around with weight on it, and walking with the milk crate with a certain amount of weight back and forth. (10/27/20 T. 21-23)

On February 15, 2018, Petitioner began working in the warehouse, being a mine monitor. He does not have to lift more than 50 pounds doing that job. (10/27/20 T. 26-27)

Petitioner started new jobs examining the elevator on May 7, 2018, and doing receiving. Since they fixed his hip, Petitioner testified he feels "a lot better." He never regained the stability or the longevity, "stamina of my knee to functionally like keep doing things for an extended period to me. My hip does feel better…it gets to a point where it starts shaking real bad and I just have to take a break." (10/27/20 T. 31)

Since the hip surgery, the stability and the strength are different in that leg. Petitioner stated his knee was unstable. (10/27/20 T. 32-33) Petitioner testified that he will have to start locking his knee in place while walking so that he has some stability in knowing that it is not going to give out on him. When his knee starts shaking like that, there is a good chance of it going out, so he tries to stop that situation by either, "if I am standing, locking it in place so that-or I will just put more weight on my other leg to try to give it a break, or I will just get off of it in general just so I do not have that risk of it not functionally working like I need it to work. My groin has gotten better since the hip surgery. Yes, that was related to the hip." (10/27/20 T. 34)

Petitioner has not been underground since August 2017. He had surgery on his hip on October 25, 2018. (10/27/20 T. 36) Dr. Wolters released Petitioner to full duty work on February 27, 2019, with the sole restriction of "no squatting." He saw Elizabeth Cheney, Dr. Wolters' nurse practitioner after the May 10, 2020, functional capacity test. He did not see Dr. Wolters. NP Cheney changed his restrictions to no more than 50 pounds of weight with regard to the hip. (10/27/20T. 37-38)

Petitioner's current job is essentially being a mine monitor and a warehouse job since his return to work in February 2019. (10/27/20 T. 39-40)

Janine Westlake testified for Respondent. Westlake works for Respondent as a Human Resources Manager since April 2019. Prior to that time, she was a Human Resources representative working under Ralph Hill. Hill has since retired. RX2 are the various physical agility tests that Mr. Dunlevy took. They were administered by Memorial Industrial Rehab. (10/27/20 T. 42-44)

Westlake confirmed all mining techs and all warehouse or mine monitor employee candidates that have been offered the job take the test. The tests are what she relies upon to place the workers. They are required to be able to perform these duties in order to get the job. (10/27/20 T. 44-45)

Medical Opinions Commission Hearing October 27, 2020

Dr. Brett Wolters (PX23)

Dr. Brett Wolters testified via evidence deposition on March 15, 2019. Dr. Wolters treated Petitioner for about four years. On May 12, 2017, Dr. Wolters wrote an opinion letter. He testified that Petitioner had a long-standing history of pain regarding his left knee from the injury he sustained. And then he developed patellofemoral syndrome, which definitely altered his gait. Dr. Wolters operated on his knee and Petitioner improved initially with his knee pain after surgery, but then had recurrence of pain and altered gait pattern. Dr. Wolters thought the extended period of time that he had symptoms from the fracture, the recovery from the nail removal, as well as the physical therapy were reasons that he thought the knee was causing the hip pain. From a mechanism standpoint, that would depend on how the individual is injured. If you break your leg if you fall backwards or forwards, you could put undue stress on the hip. (PX23, 4-6)

However, Dr. Wolters opined that a cam lesion is something that is developmental. It's not caused by any injury. He went on to say that a cam lesion makes you more susceptible to injury to the labrum. So if you have a cam lesion, you are more likely to have hip problems because it is extra bone that probably was not originally designed to be there. As the individual grows, there is more bone that forms on the outside of the hip. As you repetitively flex the hip, sometimes patients can get labral tears due to this condition. About 50% of labral tears are idiopathic or degenerative and 50% of them are traumatic.

Dr. Wolters was not aware of any evidence that having a cam lesion and severe fracture would make it more likely to develop a labral tear. "But that both of them together, there is no-you know, there is not like studies on that or anything. But certainly, if you are not able to use your leg properly for an extended period of time, you are going to have to use your hip more. And the cam lesion could further induce labral tearing."

The August 18, 2017, MRI report from the radiologist noted that there was a possible cam lesion. It further stated: Cam-type left femoral acetabular impingement. No acute osseous abnormality. No arthritis. No effusion. No gross labral tears. It was a 1.5 Tesla magnet. Poor quality MRI technique. It is not an arthrogram. He obtained a second left hip MRI on August 24, 2018.

Dr. Wolters suspected a labral tear at the time of the Petitioner's September 15, 2017, office visit and discussed with Petitioner that sometimes the MRI does not show a labral tear definitely. He thought that because Petitioner had pain with impingement testing and FABER testing of the left hip. He had some mild decreased internal rotation of the left hip. The location of his pain, the type of pain he was having was consistent with a labral tear of the hip. (PX23, 7-10)

Petitioner had an MRI arthrogram done August 24, 2018. The quality compared to the one in 2017, was improved significantly because it is an arthrogram. It is also on a three Tesla magnet, which is a more powerful magnet. And the quality of the scan was much better too. There was an obvious labral tear of the hip and cam deformity too. The cam deformity was pre-existing.

Dr. Wolters performed the surgery on October 25, 2018, and confirmed that Petitioner had a labral tear. He had some cam impingement and some mild pincer impingement as well. That is overgrowth of the acetabula, commonly seen together. Both overgrowth on the ball in the socket or the femoral head and acetabula. They would not be related to trauma but was the way he was born. Dr. Wolters testified that he fixed them all including a three anchor labral repair.

Dr. Wolters then testified that it was his opinion that the accident was a factor in his labral tear considering the prolonged recovery the patient had. He started treating Petitioner many months later; nine or 12 months later after the original injury. But he saw the patient multiple times. He definitely had significant discomfort that was relieved with the surgery initially, but then recurred, unfortunately. (PX23, 10-12)

Hip pain-hip problems can present as knee pain he testified. It typically occurs in younger patients. So that is one possibility. "He is younger, but he is not in the age category where we usually see that." Dr. Wolter testified that you can see that present as knee pain in this age population. It could be that part of the knee pain was related to the hip; the altered gait, the knee pain causing adjustments and how he moved his leg. He had groin pain related to the hip and he showed signs of trochanteric bursitis, however, Dr. Wolters did not check for that during the surgical procedure. Dr. Wolters assigned a sole restriction on February 27, no squatting. He hoped it would not be permanent and that he could get rid of that eventually; he assigned no lifting or other restrictions. (PX 23, 12-14)

On cross-examination of Dr. Wolters by Respondent's attorney, Dr. Wolters agreed that his initial treatment was for the tibia/fibula fractures and the pain related to the nail and knee pain that he had. The fractures were distal shaft-towards the ankle and he had a proximal fibula fracture which is towards the knee. The tibia fracture was towards the ankle. The fibula fracture was towards the knee. He treated Petitioner after the August 2014 accident until, roughly, October of 2015, and gave him full-duty release on October 9, 2015. He had no hip complaints at that time. He saw him again on May 12, 2017, and that was the first time that he complained about his hip. (PX23, 16-17)

The sole restriction imposed was no squatting greater than ninety degrees. The August 2017 MRI did not show any labral tear. On August 11, 2017, Dr. Wolters placed him off work until after his MRI. He was seen on September 15, 2017, and was released to return to work full duty; no restrictions.

Between September 15, 2017, and the second MRI on August 24, 2018, there were no restrictions imposed. On September 11, 2018, he was taken off work until further notice, waiting surgery approval. Surgery was performed on October 25, 2018. (PX23, 18-19)

The surgery was successful with no complications. Dr. Wolters addressed the labral tear,

impingement and the cam lesion, which are the same thing he stated. The impingement of the cam- and/or cam lesion, these were not related to the accident. The cam lesion can, by itself, cause a labral tear. Mr. Dunlevy was still under Dr. Wolters's care and treatment for the hip surgery. He was released to return to work on February 27, 2019, with no squatting but no other restrictions were placed on him at that point in time. (PX23, 20-22)

On redirect examination of Dr. Wolters by Petitioner's attorney, he testified that the cam lesion did not cause symptoms. It can cause instability of the labrum and then eventually tearing of the labrum or it can induce traumatically a labral tear too. The cam lesion is definitely a component of the labrum tear. Dr. Wolters testified that he does not typically see labral tears in this fashion in patients who do not have cam lesions.

Dr. Wolters thought Petitioner was probably non-weight-bearing or minimal weight-bearing for a long time. He had to hold his leg in a different position in order to keep his knee from hurting or keep his weight off his leg and that can make the torn labrum symptomatic. The snapping hip was caused by overusing his iliopsoas to compensate for his knee issue or his hip issue. (PX23, 22-24)

On recross examination of Dr. Wolters by Respondent's attorney, Dr. Wolters testified that he did not specifically discuss the Petitioner's gait in October 2015. Petitioner still had some discomfort in his knee if he just kind of immobilized it. He was not using it. He felt better if he was active, actually. (PX23, 25)

On further examination of Dr. Wolters by Petitioner's attorney, Dr. Wolters testified the first time that they talked about the left hip was on May 12, 2017. The fact that he did not recover after the cortisone injection suggests that he had a labral tear in May 2017. (PX 23, 25-26)

Dr. Krause Deposition (RX3; PX10) May 22, 2019

On direct examination, Dr. Krause testified that he is a board certified orthopedic surgeon and limited his practice to the care and treatment of orthopedic issues pertaining to the legs and feet. He examined Petitioner on two occasions. The first time was on July 24, 2017, and he prepared a report marked RX2, a four-page report dated July 24, 2017. His opinion was based on that examination of the Petitioner's medical conditions. His diagnosis was a left tibia and fibula fracture that healed with intramedullary fixation. He had left posterior malleolus fracture that healed and anatomic alignment, he had left knee pain likely from the patellar femoral joint, the kneecap joint, and had left trochanteric bursitis. He was at MMI in July 2017 with regard to the left tibia fibula fractures. (RX3, 4-6)

To a reasonable degree of medical certainty, Petitioner did not need any work restrictions or restrictions of activities at that point. The left ankle posterior malleolus fracture was also healed. He was at MMI with regard to that condition and Dr. Krause did not think Petitioner needed any restrictions on his activities pertaining to that injury. It was his opinion that Petitioner did not need ongoing treatment for either the tibia-fibula fracture or the post-malleolus fracture. Dr. Krause also diagnosed Petitioner with left knee pain likely from the patellofemoral origination-he was at MMI as to that condition as well. Regarding Petitioner's knee, it was his opinion that he was not at MMI

and that physical therapy was reasonable and potentially an MRI would be reasonable if he did not get better; he assumed the MRI would be negative. If that was negative, a corticosteroid injection in the knee to treat the patellofemoral symptoms was reasonable. He also diagnosed left trochanteric bursitis and Petitioner was not at MMI for that condition. Treatment for that would be stretching the iliotibial band either on your own or with physical therapists, anti-inflammatory medications and potentially a corticosteroid injection. It was his opinion that all four conditions were causally related to that accident. (RX3, 7-9)

Dr. Krause saw Petitioner again on November 19, 2018. The December 10, 2018, report was an addendum with no visit. Petitioner was having hip pain, he had undergone hip arthroscopic surgery three weeks earlier and presented on crutches and was non-weightbearing for six weeks after his hip surgery. To a reasonable degree of medical certainty the surgery he had in late October 2018 was not causally related to his work injury of August 28, 2014. He had a cam, he had impingement in his hip, femoroacetabular impingement, that is congenital. That bony abnormality works down the labrum and leads to labral tears. He got the labral tear from an abnormality that he had, he testified. Labral tears do not come from weightbearing they come from the femoroacetabular impingement that he had in his hip. The surgery performed in 2018 was to correct or repair the labral tear and to resolve some impingement in the hip as well as the cam defect. At the time of Dr. Krause's first exam, Petitioner had had an MRI of the hip, but Dr. Krause did not have the films; he had only the August 18, 2017, report. Petitioner had hip and knee MRIs on August 18, 2017, and the report stated that he had no labral tears. A labral tear is not something that is normally missed on the MRI, that is why you get the MRI to look for a labral tear. So they are infrequently missed in 1999 or 1997, 2017 they are very rarely missed with the high-quality MRIs we have these days, he stated.

Dr. Krause testified he was of the opinion in 2017 that Petitioner was capable of working without any restrictions, including in his job as a coal miner. When he saw him in 2018, Petitioner was coming off surgery and he was not able to work-he was non-weight-bearing per Dr. Wolters' recommendations. Dr. Krause testified he would not anticipate Petitioner would be able to do full-duty with the restrictions Dr. Wolters put him on, although it was his opinion that the restrictions were unrelated to the injury of August 28, 2014. (RX3, 10-12)

The cam defect was absolutely not caused by the work accident, he testified, that has a congenital abnormality in the femoral neck that causes the bony part of the femoral neck to pinch up against the labrum, the cartilage around that socket, and it just wears it down and causes a tear over time. There is no presumption that a cam deformity is a traumatically induced injury; it is a congenital abnormality.

Dr. Krause stated his opinion to a reasonable degree of medical certainty as to whether or not the work accident could have aggravated the cam defect was no. A cam defect is an abnormality of the bone, so the cam defect in and by itself does not cause pain. Over time it wears down the cartilage around acetabulum, which is the socket. It doesn't make the cam defect any worse, it's just a bony prominence; so the injuries don't make that worse. Dr. Krause further testified that the impingement in his hip was not caused or aggravated by the work accident and the injuries he sustained in it. He explained that "the femoral acetabular impingement is the bony deformity of the cam deformity impinging on the acetabulum, the labrum, so he has that, that's a congenital

thing, work injury doesn't cause that or exacerbate that or anything, it's just—it's there, he had that independent of the work injury." (RX3, p. 14)

Dr. Krause testified that the trochanteric bursitis in the left hip was not caused or aggravated by the work accident. The trochanteric bursitis is on the outside part, the lateral side of the hip. The impingement and labral tear is on the inside of the joint, they are not anywhere close to each other. So one does not affect the other.

Dr. Krause testified that it was his opinion to a reasonable degree of medical certainty that the labral tear was not caused or aggravated by his injury of August 28, 2014. Dr. Krause further testified that to a reasonable degree of medical certainty the surgery performed by Dr. Wolters that Petitioner underwent in October 2018 in his left hip was not caused or due to either in whole or in part to the work accident he sustained in 2014. It was completely unrelated to the injury of August 28, 2014, that injury played no part in the need for that surgery. Further, Dr. Krause testified to a reasonable degree of medical certainty that Petitioner did not need any work restrictions regarding his work injury. Any of the work restrictions were related to his surgery and unrelated to his work injury. (RX3, 13-15) The Industrial Rehab note on October 17, 2017 that was authored by Mr. Ravenhill, indicated the patient had decreased tolerance to sitting in addition to other restrictions and it was his opinion the patient could only function at a medium demand level. Dr. Krause had seen the patient on July 24, 2017 and thought he could do full duty; so three months earlier Dr. Krause saw him and said he could do full duty. Dr. Krause opined that the Industrial Rehab note is somewhat odd in that the patient had decreased to sitting tolerance and was not sure if he had seen that note, what he means by that, if he thinks the patient has to be lying down or whatever, but that is certainly a red flag… difficulty standing for long periods of time or other restrictions are reasonable, but when they say they have decreased sitting tolerance, it certainly brings the validity of the report into question. (RX3, 16-17)

On cross-examination, Dr. Krause testified that he has no experience in the mines. He did not know the terms "man trip," "belt move," "donut crib," how many square feet or miles there are in the mine where Petitioner works. (RX3 17-19)

Dr. Krause did not know how much crouching Petitioner had to do or how long he has to stand or how much squatting he has to do or the periods of time he has to squat. Dr. Krause saw Petitioner on July 24, 2017 and he was already having hip pain at that time. He did not have snapping when Dr. Krause saw him in his office. He had tenderness over his greater trochanter, which is not the hip joint, it's up by the pelvis, he testified. A lay person would call it the hip but a doctor generally wouldn't call that the hip, he stated. Petitioner had tenderness over the trochanteric bursa so it would be called bursitis which he was diagnosed with that in April 2017. Dr. Krause thought Daniel Lanzotti diagnosed it but was not sure if Dr. Wolters diagnosed it or not. (RX3, 20-22)

Dr. Krause testified that it is hard to know what caused the trochanteric. It could be from an altered gait, he could have fallen on that side, he could have had direct trauma. Petitioner did not give a good history of why he got that, he just presented in April of 2017 complaining of hip pain and to the best of his recollection there is no extensive history of how it came about. Dr. Krause testified that he thought he said in his note that it was not uncommon to get trochanteric

bursitis following a left lower extremity injury that caused him to walk with an altered gait. So he couldn't say that with any certainty but it's not unreasonable to conclude that. Bursitis generally causes pain.

He couldn't say with any certainty that the bursitis was caused by the work accident, but it's not unreasonable to tie them together. When Dr. Krause saw him in November of 2018 it had resolved, however, he did not know when it went away or what caused it to go away. This is not something you could see on a radiograph. It's possible he never had it. When he saw him in July 2017, Dr. Krause documented that Petitioner walks w/out a limp on the left; thus he did not know that he had an altered gait. In November of 2018, he was non-weight bearing; he had just come off his surgery. He would have been non-weight bearing; he wouldn't have had him do a walking or a gait exam. Those were the only two times he was seen.

Dr. Krause did not review the August 18, 2017, MRI. He did not know what kind of magnet was used. Dr. Wolters ordered it so he probably would know that. Dr. Krause presumed that Dr. Wolters thought the quality of the MRI was good, because he sent it. He had not reviewed his deposition. He did not think he had either MRI; he just read the report. The second August 24, MRI was an MRI arthrogram but he was not sure as he did not have a record of that right in front of him. (RX3, 23-25)

Dr. Krause verified that he did not know what type of MRI was taken on August 24 and he could not say when the labral tear started. It was definitely after the August 17 MRI, absolutely. He just did not know when it started. According to the report, and he did not review the MRI image, but according to the report it was not there on the August 18, 2017 MRI. Dr. Krause would not opine whether or not the surgery Dr. Wolters performed was necessary because he had not seen the MRIs. Petitioner had a cam lesion, but trauma cannot make a cam lesion more symptomatic or make the exam symptomatic. The lesion itself is not symptomatic. The lesion itself is a bony prominence on the femoral neck; so it is a bump on the femoral neck, so that does not become symptomatic. The labrum becomes symptomatic from the bony "thing rubbing on and impinging on the labrum and you just wear down and you get a tear over time…. So trauma, you can have a traumatic labral tear or you have a labral tear from chronic attrition from this cam lesion. Most of the labral tears that you see…" So chronically bone pinching on this cartilage over time you get attrition and it tears. A lot of people are asymptomatic with time. Dr. Krause testified that he would argue that the vast majority of people who have cam lesions over time become symptomatic and that is why a lot of surgeons recommend prophylactic surgery to shave that lesion down even if they have minimal symptoms. The cam lesion is a bony growth or bony lesion, and when that rubs against the labrum it wears down the labrum and eventually tears. (RX3, 26-28)

Dr. Krause testified that an altered gait does not make it worse or make it better. Dr. Krause testified that potentially an altered gait would make it better if you are not moving your hip as much, meaning, you get the impingement with flexion and rotation.

The impingement comes--the acetabulum is the socket part of the ball and socket joint; the labrum in (sic) the cartilage rim around that socket and the femur is the ball and the ball part of it, the neck of the femur, has this bony lesion on it or a bony abnormality that when you flex your hip and you internally rotate, that hits on the cartilage on the socket and over time that wears that down

similar to you know anything wearing down, you know, something that gets traumatized over and over again, it slowly breaks down and tears. So the acetabular impingement of the cam lesion moving against the labrum leads to a tear. (RX3, 32)

On redirect examination, Dr. Krause testified that for purposes of an IME, his exam does not differ in any way from what an exam would have been if the patient came in for treatment. The labral tear is not at or near the place where the bursitis was diagnosed-they are not close to each other anatomically. The bursitis is on the outside part of the hip and the labral tears on the inside, they have got to be 10 or 12 cm apart. If someone experienced pain from the labral tear the pain would be in a different area that it would be from the pain of bursitis. Trochanteric bursitis causes pain on the outside part of the hip, typically pain when you are lying on that side. When people say it they point to the outside part of their hip, whereas labral tears cause groin pain. So they point in the groin almost in a hernia type area, so they are really not easy to confuse. When Dr. Krause saw Petitioner in 2017, he did not complain of or indicate he had any groin pain. (RX3, 33-34)

Functional Capacity Evaluation

Petitioner underwent a Functional Capacity Evaluation (FCE) on May 20, 2020. The Petitioner's medical surgical history unrelated to this onset includes screw placement in the left foot to repair fractured metatarsal, tendon repair in the left hand, screw placement in the left hand, and left shoulder closed reduction. The remaining history reflects that the client underwent work conditioning at Memorial Industrial Rehab from October 17, 2017 through October 26, 2017, a total of five appointments ceasing treatment due to increasing left hip and low back pain with left hip surgery eventually required. No additional PT or work conditioning was formally completed after surgery, as the client states that workers compensation denied any treatment related to the left hip, feeling this was unrelated to the original injury sustained on the job.

Functional status/activity level: at the time of injury the client was employed by Arch Coal is a mine tech, primarily working underground. He was off work following injury and multiple surgeries; however, he has since returned to work where he is placed above ground working within the control room and the warehouse rather than underground as a mine tech. He has been placed in this role since "failure" of physical agility test two years ago to return to mine tech work. The client states his current duties include a lot of walking, lifting and lowering items weighing less than 50 pounds, driving a forklift, climbing ladders to get into loaders, retrieving workers from different areas, desk and computer work, watching monitors, checking underground cage/emergency escape exit and assessing coworkers. He states that he currently works 11 hour shifts, four days a week. The client does not feel he would be able to return to underground mine tech work noting that he does not feel like he has the longevity to complete the physical demand of the job, as he does not feel he could keep up this pace of heavy physical work for eight hours, let alone the ten hours that is now required of the position.

Client states the current restrictions, set in place by Dr. Walters, include no squatting but FCE testing was recommended to determine permanent restrictions. Client was with his wife and two daughters, ages five years and an infant, and reports he currently works 10 to 11 hour days. He denies needing any assistance with any of his daily responsibilities, including home

maintenance yardwork and states that he is independent with his self-care, transportation and daily chores. He notes he is able to mow the lawn with a push mower but his left knee can start to feel weak, causing him to limp but, without pain. When asked about hobbies the client states he used to be able to ride a bike but this now causes left knee pain, mostly after the activity, which confuses him as he reports he was previously able to ride an exercise bike without symptoms when he was at therapy. He notes he also likes to play with his five-year-old daughter, but because of the left knee, is unable to "run around" and play as much. He states he does not lift his five-year-old reporting that she weighs more than 50 pounds and can be "too wiggly" but he denies any problems with lifting, holding or carrying their infant daughter.

FCE completed to evaluate to determine functional abilities and/or limitations:

The client demonstrated cooperative behavior and was willing to work maximum abilities and all test items. Movement patterns and physiological responses were consistent with maximal effort.… Client's perceived abilities, as measured on the spinal function sort, are lower than those objectively identified in the FCE. Client's composite score on the SFS was 130 which is within the "light" DOL category in which scores should range 125-135. Client's current functioning level is with the "medium" DOL category (21-50 pounds) for waist to floor lift, front carry and waist to crown lift. SFS scores reflective of the "medium" DOL category should range 155-175.

Abilities/strengths

- Material handling capabilities within the "Medium" DOL category for waist to floor lift, waist to crown lift and front carry
- Sitting and standing work tolerance
- Positional tolerance for weighted elevated work
- Fair static push/pull abilities
- Low work positional tolerance for kneeling
- Right hand grip strength within age and gender norms
- Functional strength and active ROM of the spine
- Bilateral upper extremities and lower extremities
- Good abilities for repeated toe rise and repeated squat reps
- Good static standing balance over even and uneven surfaces
- Functional coordination of gross motor movements

Limitations:

- Decreased 6MWT/Walking distance accompanied by symptom reports
- Stair climbing ability, partially ltd due to limitation with walking
- Ladder climbing ability, partially ltd due to limitation with walking
- Low work positional tolerance for crouching
- Positional tolerance for forward bend on standing
- Left hand grip strength below age and gender norms, with known L hand involvement unrelated to referral diagnoses

The client is currently functioning within the "Medium" DOL category (50 pounds) for waist to floor lift, front carry and waste to crown lift. No modifications were necessary to achieve these

levels. See DOL strength demands grid below.

Summary/Recommendations: Client gave maximal effort throughout the evaluation. He is currently functioning within the "Medium" DOL category for material handling tasks of waist to floor lift, waist to crown lift and front carry. He was able to implement safe body mechanics and postures with FCE testing activities following instruction without need for modifications. Client occasionally verbalizing symptoms in the left knee with select subtests, but he was able to complete all tasks as requested without self-limitation. Objective signs of maximal effort were present. Push/pull values were consistent with each trial and pull force was greater than push force consistent with maximal effort. Forces generated with right hand grip strength trials were within age and gender norms bilaterally and consistent between trials while grip trials were below age and gender norms with this attributed to previous left hand surgery unrelated to referral diagnoses. Quality movement with testing was smooth and coordinated with tasks. Client's perceived abilities per spinal function sort questionnaires are lower than his functional abilities objectively identified with FCE subtests. He has been working in a different job title than when he was injured. He does not feel he is able to return to his former position at this time and per client reports, FCE testing is being completed to determine need for permanent work restrictions.

With FCE testing the client displayed limitations of decreased walking, decreased stair and ladder climbing abilities, and decreased positional tolerances for crouching and for forward bend in standing. The client demonstrated that he's currently able to perform waist to crown lift in front carry with 50 pounds on occasion and he is able to perform waist to floor lift with 40 pounds on an occasional basis. A formal job description was not provided by the client's current employer for FCE testing as the client reports that FCE testing was not requested by his employer, but rather by his M.D. to determine need for implementation of permanent activity/work restrictions.

These projections are for eight hours a day five days a week at the levels indicated on the FCE grid. Medical correlation is required with above recommendations.

Findings of Fact

At the time of the Arbitration hearing, the Petitioner suffered injury to his left knee, left ankle and left great toe. The Petitioner did not have an FCE at the time of the Arbitration hearing, however, the Petitioner described similar limitations in that he had rituals of bathing, stretching and ways to work out the locking of his left leg at that time. The Petitioner was released to work full duty at the time of the Arbitration hearing. He was awarded 45% loss of use of the left leg for the injury he sustained in the work accident of August 28, 2014.

At the time of the Commission hearing, Petitioner had a new medical condition and diagnosis of a labral tear and subsequent surgery to his left hip, which was congenital in nature. He had limitations imposed after a hip surgery, however, was released to full duty work at the mine in the warehouse and as a mine monitor. The Commission is not persuaded that the Petitioner's limitations were different at the time of his Commission hearing in regard to his knee or ankle or left great toe than what he described at arbitration. The Commission finds that Petitioner has not proven that his condition of ill-being with respect to his left knee, left ankle or left great toe are materially changed since the arbitration hearing.

The Commission further finds that even if the Petitioner's condition had materially changed, that the Petitioner's material change was not causally related to his work accident in August 2014. The Petitioner's current condition changed and restrictions were imposed because he had a left hip surgery for a labral tear in 2018. The Commission finds specifically that Dr. Krause is more credible than Dr. Wolters's opinion given that Dr. Wolters agreed that the cam lesion caused the labral tear. The Commission finds Dr. Krause credibly testified that the cam lesion is a congenital abnormality and that the cam lesion caused the Petitioner's left hip labral tear.

The Commission finds that Dr. Krause's testimony was bolstered by Dr. Wolters who also testified that Petitioner was born with the condition and Dr. Wolters testified that a cam lesion is not caused by injury. Dr. Krause credibly testified that Petitioner got the labral tear from an abnormality that he had, that labral tears do not come from weightbearing, they come from the femoroacetabular impingement that he had in his hip. The surgery performed in 2018 was to correct or repair the labral tear and to resolve some impingement in the hip as well as the cam defect. Dr. Krause further testified that the cam defect was absolutely not caused by the work accident; that it was caused by the congenital abnormality in the femoral neck that causes the bony part of the femoral neck to pinch up against the labrum, the cartilage around that socket, and it just wears it down and causes a tear over time. There is no presumption that a cam deformity is a traumatically induced injury; it is a congenital abnormality.

Dr. Krause further testified that his opinion to a reasonable degree of medical certainty as to whether or not the work accident could have aggravated the cam defect is no. He explained that a cam defect is an abnormality of the bone, so the cam defect in and by itself does not cause pain. Over time it wears down the cartilage around acetabulum, which is the socket, so no, it does not make the cam defect any worse, it's just a bony prominence; so the injuries do not make that worse. Dr. Krause further testified that the femoral impingement in Petitioner's hip was not caused or aggravated by the work accident and the injuries he sustained in it. Dr. Krause testified that "the femoral acetabular impingement is the bony deformity of the cam deformity impinging on the acetabulum, the labrum, so he has that, that's a congenital thing, work injury doesn't cause that or exacerbate that or anything, it's just—it's there, he had that independent of the work injury." (10/27/20 C. Hearing RX3, p. 14)

The Commission is not persuaded by Dr. Wolters' further opinion that the Petitioner's altered gait caused the labral tear to become symptomatic because the Commission finds no such notation about an altered gait in Dr. Wolter's medical records. In fact, Dr. Wolters testified that he did not discuss any such theory with Petitioner at the time of his October 2017 office visit. Further, Dr. Wolters testified that there were no studies to support a theory that a severe fracture would make it more likely for the Petitioner to develop a labral tear. He had released the Petitioner to full duty work in 2015 with no restrictions. He also opined that he had hoped Petitioner's squatting restrictions would not be permanent as a result of the hip surgery.

The Commission finds Dr. Krause's opinion more persuasive than Dr. Wolters' equivocal opinion. Dr. Krause testified as follows:

The lesion itself is not symptomatic. The lesion itself is a bony prominence on the

> femoral neck; so it is a bump on the femoral neck, so that does not become symptomatic. The labrum becomes symptomatic from the bony thing rubbing on and impinging on the labrum and you just wear down and you get a tear over time…. So trauma, you can have a traumatic labral tear or you have a labral tear from chronic attrition from this cam lesion. Most of the labral tears that you see… So chronically bone pinching on this cartilage over time you get attrition and it tears…A lot of people are asymptomatic with time. I think I would argue that the vast majority of people who have cam lesions over time they become symptomatic and that is why a lot of surgeons recommend prophylactic surgery for that to shave that lesion down even if they have minimal symptoms. (10/27/20 C. Hearing RX3, 27-28)

Finally, Dr. Krause testified that any of the work restrictions were related to his surgery and unrelated to his work injury. (RX3, 13-15) Therefore, the Commission further finds that the restrictions imposed were a result of the left hip surgery, therefore, there was no material change in the Petitioner's condition. Further, the Commission finds that the left hip surgery was unrelated to the work injury of August 2014.

Conclusions of Law

§19(h) of the Act provides, in pertinent part, that

> ". . . as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement may at any time within 30 months, or 60 months in the case of an award under § 8(d) 1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended." *Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h).*

Based on the above, and the record taken as a whole, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that his disability has materially increased since the prior decision.

It appears that the evidence of Petitioner's disability submitted as part of the present §§19(h)/8(a) Petition differs little from the evidence submitted at the time of arbitration with respect to Petitioner's left leg, left knee, left ankle and left great toe. Nothing has really changed in terms of Petitioner's left knee condition other than the fact that he has subsequently undergone a functional capacity evaluation wherein it was determined that he had restrictions of no squatting and lifting less than 50 pounds. Petitioner testified that the restrictions were for the left hip. (10/27/20 T. 39)

Petitioner did not undergo an FCE at the time of the arbitration hearing but testified extensively of residual left ankle and left leg problems. With regard to his left leg, Petitioner testified at Arbitration that he normally gets in the hot tub, depending on the weather, and he sits

in it for an hour and a half while he tries to move his leg back and forth. The warm water helps it if he can get it hot enough. He likes to have the massaging jets on it when he is in the hot tub in the morning. Petitioner also testified that he gets up and walks around to limber his leg up. If he does not limber it up as described, he feels weak and he will lose a lot of range of motion.

Petitioner continues to complain of left knee pain only now he claims that the stability and strength differs since the last hearing. Unfortunately, other than his own self-serving testimony along these lines, there is no objective evidence and/or diagnostic studies to support such a claim that his left knee condition changed. Petitioner's attempt to characterize the physical agility test results as proof of a material change is unconvincing. Petitioner's described but unrelated left hip pain would have affected his performance for the physical agility test and certainly after the hip surgery, the left hip condition would have affected the functional capacity test. As a result, the Commission finds that Petitioner failed to prove that his disability has materially increased since the prior Commission Decision and Opinion on Review.

After hearing the parties' arguments and carefully reviewing the record, the Commission finds the preponderance of the evidence shows a substantial similarity between Petitioner's condition of his left knee, left leg, left ankle and left foot great toe at the August 25, 2016, Arbitration Hearing and at the time of the October 27, 2020, Commission Hearing. The Commission further finds that the Petitioner has failed to prove that his condition in his left hip is causally related to the August 28, 2014, work accident. Thus, the Petitioner has failed to prove a material change in his disability since the Arbitrator's Decision issued on October 27, 2016, and has failed to prove his condition of ill-being is causally related to the original August 14, 2014, work injury. Thus, Petitioner's § 19(h) and §8(a) Petition is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under § 19(h) and §8(a) of the Act is hereby 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.

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.

August 9, 2021

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

KAD/bsd
O060821
42

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

/s/*Stephen Mathis*
Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC003757
Case Name	ESPANA,JUAN v. US REFRIGERATION SALES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0408
Number of Pages of Decision	23
Decision Issued By	Maria Portela, Commisioner

Petitioner Attorney	Charles Romaker
Respondent Attorney	Timothy O'Gorman

DATE FILED: 8/11/2021

/s/ Maria Portela, Commissioner

Signature

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

JUAN ESPANA,

Petitioner,

vs. NO: 19 WC 3757

US REFRIGERATION SALES & SERVICE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability and medical expenses, 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. 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).

In the second paragraph on page 6, we strike the sentence beginning with, "Once that opinion was given…." The Commission notes that this sentence is inconsistent with the Arbitrator's denial of penalties against Respondent.

Also on page 6, we modify paragraph four to begin with "On February 18, 2020" instead of "On February 22, 2020."

On page 9, we strike paragraphs four and five in their entirety.

Under "Issue K," on page 9, we strike the rest of first the sentence that begins with "Respondent stopped paying TTD…" after the words "10/8/2019 IME report." We also add the following sentence: "The Commission notes that Dr. Holmes did not re-examine Petitioner on

October 8, 2019, and at the time of the evaluation on July 17, 2019, Dr. Holmes opined Petitioner could only stand 5-15 minutes per hour and, furthermore, could not climb, kneel or squat."

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 1, 2020, is hereby affirmed and adopted with the changes noted above.

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

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

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

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

August 11, 2021

SE/
O: 6/22/21
49

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

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

21IWCC0408

ESPANA, JUAN
Employee/Petitioner

Case# **19WC003757**

U S REFRIGERATION SALES & SERVICES
Employer/Respondent

On 10/1/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Juan Espana
Employee/Petitioner

v.

U S Refrigeration Sales & Services
Employer/Respondent

Case # **19WC003757**

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 **July 27, 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 - Is Petitioner entitled to any prospective medical care?

FINDINGS

On the date of accident, **January 22, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

On **January 22, 2019**, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On **January 22, 2019**, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent on January 22, 2019.

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

In the year preceding the injury, Petitioner earned wages of $33,761.52 and the average weekly wage was **$649.26**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall pay Petitioner temporary total disability benefits of $432.84 per week for 78 and 6/7ths weeks, commencing on January 22, 2019 to the date of trial, July 27, 2020 as provided in Section 8(b) of the Act. Total TTD owed is $34,133.77. Respondent shall be given a credit of $24,239.04 for TTD paid, leaving $9,894.73 in TTD due and owing to Petitioner.

ORDER

Is Petitioner's Current Condition of ill-being causally related to the injury?

Based on the testimony of Petitioner and the medical records of Dr. Narendra Patel and Dr. Anish Kadakia, as well as Dr. Holmes' opinion that the left ankle injury was caused by the work accident, Petitioner's left foot and left leg injury was caused by the work accident of January 22, 2019.

Temporary Total Disability and Credit for TTD Paid

Respondent shall pay Petitioner temporary total disability benefits of $432.84 per week for 78 and 6/7ths weeks, commencing on January 22, 2019, to the date of trial, July 27, 2020, as provided in Section 8(b) of the Act. Total TTD owed is $34,133.77, minus a credit for TTD paid of $24,239.04, leaving $9,894.73 in TTD due and owing to Petitioner.

Medical Benefits

Petitioner's medical bills were admitted as Petitioner's Exhibits 3B, and 5. The Arbitrator awards the medical bill from Alexian Brothers Medical Center in Exhibit 3B in the amount of $5,295.53 and the bill of ATI Physical Therapy in Exhibit 5 in the amount of $4,006.73.

Penalties

Penalties and attorneys fees are denied.

Prospective Medical Care

Petitioner's first treating doctor, Dr. Narenda Patel opined that Petitioner would require a left ankle revision surgery to remove the plate and seven screws in July 2019. (See PX 2, Dr. Patel 5/1/2019 Note) Petitioner's second treating surgeon, Dr. Anish Kadakia also opined that Petitioner would require a left ankle revision surgery to remove the plate and screws as well as a reconstruction of the left foot and left gastroc, which is necessary as a result of the work injury of January 22, 2019. (PX6, Dr. Kadakia's 7/19/2019 and 6/9/2020 Notes).

Respondent's IME Doctor, Dr. George Holmes, testified that he did not believe Petitioner would benefit from a second left foot surgery. (RX1, Dr. Holmes deposition, p. 24, L 17-20) Dr. Holmes did not see the weight bearing CT Scan of the left foot taken on 11/5/2019. (RX1, Dr. Holmes deposition, p. 40, L 4-6) Dr. Holmes testified that if Dr. Kadakia found widening of the syndesmosis, he would agree with a fixation surgery of the syndesmosis of Petitioner's left ankle. (RX1, Dr. Holmes deposition, p. 40, L 2-6)

The Arbitrator finds that Petitioner has demonstrated, through the medical records of Dr. Anish Kadakia and the weight bearing CT of the left ankle that the left ankle hardware removal and repair of the syndesmosis repair is reasonable and necessary. Based upon Dr. Kadakia and Dr. Holmes' opinions, this revision surgery would be reasonably related to the work accident of January 22, 2019.

Based upon the foregoing medical records and opinions, the Arbitrator awards the Petitioner the prospective medical care in the form of the left ankle revision surgery recommended by Dr. Kadakia and any other post-surgical treatment, including but not limited to, physical therapy.

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

September 30, 2020
Date

ICArbDec19(b)

OCT 1 - 2020

FINDINGS OF FACT

The parties stipulated that on January 22, 2019, Respondent, US Refrigeration Sales & Services was operating under and subject to the provisions of the Act, and that an employee-employer relationship existed between Respondent and Petitioner. (*See* Request for Hearing Form, Arbitrator's Exhibit 1, at Par. 1 and 2). The parties also stipulated that Petitioner gave timely notice of the accident on January 22, 2019 to his supervisor Steve. (Id. at Par. 3) The parties also stipulated that Petitioner's earnings for the year preceding the accident were $33,761.52 and that Petitioner's average weekly wage was $649.26. (Id. at Par. 5)

The parties also stipulated that Petitioner was 25 years old, single with one child under the age of 18 years old. (Id. at Par. 6) This matter was tried on July 27, 2020. On July 27, 2020, Petitioner was the only witness that testified at Trial. Petitioner submitted Exhibits 1 through 9 and all Petitioner's Exhibits were admitted into evidence. (Tr. Trans. July 27, 2020 at p. 13-15) Respondent's submitted Exhibits 1 through 5 and Respondent's Exhibits were all admitted into evidence. (Tr. Trans. at p. 17-18) Petitioner's Penalties Petition was admitted as Arbitrator's Exhibit 3. (Tr. Trans. at p. 11)

On July 27, 2020, the Petitioner testified that his date of birth is 12/2/1993, is single and has one dependent child under the age of 18 years old. (Tr. Trans. at p. 21 and Request for Hearing Form, Arbitrator's Exhibit 1 at Paragraph 6).

Petitioner testified that his job duties at US Refrigeration on January 22, 2019 were to deliver refrigeration units, pick up old refrigeration units, and to wash the refrigeration units. (Tr. Trans. at p. 22) Petitioner testified that he would have to lift up to 80 pounds on any given day while working for Respondent. (Tr. Trans. p. 23-24) Petitioner testified that prior to January 22, 2019, he never previously injured his left ankle or left foot. (Tr. Trans. p. 24)

Petitioner further testified that on January 22, 2019 at approximately 11:00 a.m. he was washing a commercial refrigerator with soap and water and he got soap in his eye and he started walking toward the bathroom. (Tr. Trans. at p.24-25) Petitioner testified that while he was walking, he slipped on soapy water and he twisted his left ankle and came down with his whole weight onto his left ankle, and he heard a crack in his left ankle. (Tr. Trans. at p. 25) At the time of the accident on January 22, 2019, Petitioner noted a lot of swelling and felt pain. (Id.)

Immediately after the work accident on January 22, 2019, Petitioner's left ankle began to swell up and his Supervisor Steve and the dispatcher Sandro helped him to sit down onto a chair. (Tr. Trans. at p. 25) Petitioner testified that Steve drove him to Northwest Community Health Care, where they examined him, took some x-rays and gave him crutches. (Tr. Trans. p. 26) The Doctor at Northwest Community Health placed Petitioner off work and referred him to Dr. Narenda Patel at Barrington Orthopedics. (Tr. Trans. at p. 26-27)

DR. NARENDA PATEL - MEDICAL TREATMENT

On January 23, 2019, Petitioner saw Dr. Narenda Patel at Barrington Orthopedics at the referral of the doctors at Northwest Community Healthcare. (Tr. Trans. p. 26 and PX 2, Dr. Patel 1/23/2019 Note) On 1/23/2019, Dr. Patel recommended surgery to repair the left medial malleolus fracture and placed Petitioner off work. (Id.)

On January 31, 2019, Dr. Patel performed an open reduction, internal fixation surgery of the left malleolar fracture and an open reduction and internal fixation of the left syndesmotic disruption of Petitioner's left ankle. (PX 2 and PX 3A, and Operative Report of 1/31/2019) In that surgery, Dr. Patel installed seven (7) screws, a titanium anchor and a metal plate to Petitioner's left ankle, tibia and fibula. (Id. and Tr. Trans. p. 28 and p. 31 and PX 9)

On February 6, 2019, Petitioner had a follow up visit with Dr. Patel. (PX 2 at Dr. Patel 2/6/2019 Note) Dr. Patel's diagnoses were acute disruption of the left ankle syndesmosis, closed fracture of the shaft of the fibula and closed fracture of the medial malleolus of the left tibia. (Id.) Dr. Patel applied a cast to the left ankle / left foot, placed Petitioner off work and his plan was to take the staples out at the next visit, to prescribe physical therapy and to have "the hardware removed in the future with possible arthroscopy of the ankle as it is common for these types of injuries to cause irritation to the joint and pain from the hardware." (Id. at p. 3 and Tr. Trans. p. 28)

On February 20, 2019, Petitioner again had a follow up visit with Dr. Patel. (PX 2 at Dr. Patel 2/20/2019 Note) Dr. Patel removed Petitioner's cast and installed a short leg cast after taking out the staples. (Id. and Tr. Trans. p. 28) Dr. Patel placed Petitioner off work for 6 weeks and again discussed the likely future need for a surgery to remove the hardware in the left ankle. (Id.)

On March 6, 2019, Petitioner again had a follow up visit with Dr. Patel. (PX 2 at Dr. Patel 3/6/2019 Note) Dr. Patel ordered Petitioner off work and prescribed physical therapy two times a week for six weeks. (Id.)

On March 20, 2019, Petitioner presented for a follow up visit with Dr. Patel with a non-weight bearing short cast and crutch assist. (PX 2 at Dr. Patel 3/20/2019 Note) Dr. Patel noted continued swelling of Petitioner's left ankle. (Id.) Dr. Patel again ordered Petitioner off work and prescribed physical therapy two times a week for six weeks. (Id.)

On March 22, 2019, Petitioner started physical therapy at Novacare. (PX 4) Petitioner underwent active range of motion exercises, therapeutic exercise and stretching / flexibility exercises at Novacare from 3/22/2019 to 4/17/2019. (Tr. Trans. p. 29 and PX 4)

On April 3, 2019, Petitioner again had a follow up visit with Dr. Patel. (PX 2 at Dr. Patel 4/3/2019 Note) Dr. Patel removed Petitioner's short leg cast and applied a sports brace and recommended full weight bearing as tolerated. (Id.) Dr. Patel again noted continued swelling of

Petitioner's left ankle. (Id.) Dr. Patel placed Petitioner off work and prescribed additional physical therapy. (Tr. Trans. p. 30 and PX 2 at 4/3/2019 Note)

On April 23, 2019, Petitioner began physical therapy at ATI Physical Therapy. (PX 5) According to the initial physical therapy note of 4/23/2019, Petitioner presented with decreased range of motion (ROM), strength, and decreased joint mobility with increased pain and edema to the left ankle. (PX 5 at 4/23/2019 PT Note) The therapist noted that Petitioner worked as a warehouse and delivery person that requires a physical demand level (PDL) of "Heavy." (Id.) At the last physical therapy visit on 7/22/2019, the therapist noted that Petitioner continued to present with impairments in ROM, soft tissue mobility, strength, edema, gait, pain upon weight bearing and lifting mechanics. (Id.) The therapist noted on 7/22/2019 that these deficits limited Petitioner's ability to carry, lift, squat, sustained standing, and walking on uneven surfaces. (Id.)

Mr. Espana had his last appointment with Dr. Patel on May 1, 2019. (PX 2, Dr. Patel 5/1/2019 Note and Trial Trans. p.32) Dr. Patel again noted continued swelling of Petitioner's left ankle. (Id.) Dr. Patel discontinued the left ankle brace, placed Petitioner on restricted sitting work only. (Id. and Trial Trans. p.32) Dr. Patel indicated to Petitioner that he was planning on doing a hardware removal surgery in a few months. (Id. and Tr. Trans. p.32)

DR. ANISH KADAKIA - TREATMENT

On May 31, 2019, Petitioner saw Dr. Anish Kadakia at Northwestern Medical Orthopedic Surgery. (PX 6) Dr. Kadakia's examination demonstrated tenderness to palpation to the left medial ankle joint as well as tenderness over the syndesmosis and the left lateral ankle joint. (PX 6 at Dr. Kadakia 5-31-2019 Note) Further, Dr. Kadakia's examination noted painful range of motion of the left ankle, decreased strength for dorsiflexion and plantar flexion. (Id.) The X-rays taken by Dr. Kadakia on 5/31/2019 demonstrated no fixation of the posterior malleolus and sub-optimal fixation of the left syndesmotic with increased medial clear space. (Id.)

On May 31, 2019, Dr. Kadakia's assessment and plan was that Petitioner was suffering from an ankle mal-union which would require a revision surgery after a weight bearing CT Scan of the left ankle. (PX 6 at Dr. Kadakia 5-31-2019 Note) Dr. Kadakia placed Petitioner off work until further evaluation. (Id. and Trial Trans. p. 33)

Petitioner had a CT of the left ankle at Berwyn Diagnostic Imaging on June 26, 2019. (PX 7 and Trial Trans. p. 33-34) Unfortunately, the CT scan performed at Berwyn Diagnostic Imaging on June 26, 2019 was a non-weight bearing CT scan of the left ankle instead of the weight bearing CT scan that Dr. Kadakia ordered on May 31, 2019. (See PX 6 at Dr. Kadakia 8/20/2019 Note)

On July 19, 2019, Petitioner again saw Dr. Anish Kadakia at Northwestern Medical Orthopedic Surgery. (PX 6 at Dr. Kadakia 7/19/2019 Note) Dr. Kadakia's examination demonstrated tenderness along the tract of the tibialis anterior as well as the Achilles tendon.

(Id.) Dr. Kadakia stated that Petitioner either had post-operative tendonitis from post-surgical changes or persistent scar tissue post-surgery. (Id.) On 7/19/2019, Petitioner was placed on sedentary duty by Dr. Kadakia. (Id. and Trial Trans. p. 34)

On August 20, 2019, Petitioner again saw Dr. Anish Kadakia at Northwestern Medical Orthopedic Surgery. (PX 6 at Dr. Kadakia 8/20/2019 Note) On that date Petitioner presented with severe pain and Dr. Kadakia performed X-rays, which showed gapping and malalignment of the syndesmosis and he noted Petitioner had a tight calf. (Id.) Dr. Kadakia also noted that the CT Scan performed on June 26, 2019 was non-weight bearing and he requested a weight-bearing CT scan of the left ankle. (Id.)

On August 20, 2019, Dr. Kadakia advised Petitioner that he could either live with the pain or undergo a revision surgery to take out all the hardware, do a deltoid reconstruction cleaning out all the scar tissue in that area, and reconstruct the syndesmosis along with a gastroc resection. (PX 6 at Dr. Kadakia 8/20/2019 Note and Trial Trans. p. 34-35) Dr. Kadakia noted that the revision surgery would be the best thing he could do to get Petitioner back to work. (Id.) On August 20, 2019, Dr. Kadakia again placed Petitioner off work until further evaluation and ordered a new weight bearing CT Scan. (Id.)

On November 5, 2019, Petitioner had a weight bearing CT scan of his left ankle at Niles Open MRI. (PX 8) One of the radiologist's impressions from the 11/5/2019 CT Scan of the left ankle was "There is evidence of partly fused malunited fracture involving he posterior malleolus."

On November 12, 2019, Petitioner had a follow up visit with Dr. Kadakia. (PX 6 at Dr. Kadakia 11/12/2019 Note) Dr. Kadakia stated that there was a subtle malalignment of the syndesmosis and that he recommended a surgery to remove the hardware and to reconstruct the deltoid and syndesmosis. (Id. and Trial Trans. p.35-36) Dr. Kadakia again placed Petitioner off work until further evaluation. (Id.)

On April 10, 2020, Petitioner had a telephonic medical consult with Dr. Kadakia. (PX 6 at Dr. Kadakia's 4/10/2020 Note) Petitioner told Dr. Kadakia he had significant pain. (Id.) Dr. Kadakia stated Petitioner needed the left ankle revision surgery discussed in November 2019 and again placed Petitioner off work until further evaluation. (Id. and Trial Trans. p. 36)

On June 9, 2020, Petitioner had his last visit with Dr. Kadakia. (See PX 6, Dr. Kadakia's 6/9/2020 Note) Petitioner presented with significant left ankle pain. (Id.) Dr. Kadakia stated that "clearly he has a syndesmotic injury. He has a tight gastroc. He has a problem with painful hardware." (Id.) Dr. Kadakia again restated the 11/5/2019 CT showed a misalignment of the syndesmosis as well as gastroc contracture. (Id.) Dr. Kadakia recommended:

> "A surgical reconstruction, I think is totally reasonable, as an open reduction and internal fixation of the syndesmosis with a combination tightrope and internal brace to stabilize the syndesmosis, a gastrocnemius recession to correct the equinus contracture, removal of hardware and then go ahead and reconstruct the deltoid with a FiberTak and to clean out the scar tissue."

(PX 6 at Dr. Kadakia 6/9/2020 Note)

Significantly, Dr. Kadakia also opined that the only way to try to get the 26 year old Petitioner back to work would be to do the surgery. (PX 6 at Dr. Kadakia 6/9/2020 Note and Trial Trans. p. 36-37) Petitioner informed Dr. Kadakia at the June 9, 2020 office visit that he wanted the left ankle surgery that Dr. Kadakia was recommending. (Id.) Dr. Kadakia again placed Petitioner off work until further notice. (Id.)

Petitioner testified that currently his left ankle is swollen most of the time and it hurts even if he is sitting down. (Tr. Trans. p. 37) He also testified that he can't walk for more than 30 minutes or stand for more than 15 to 20 minutes. (Id.) He cannot go to the park and play soccer and he cannot play with his son, who likes to run around. (Tr. Trans. p. 37-38) Petitioner testified that if he tries to walk, his left ankle swells up and he has pain near the plate and screws located on the outside portion of his left ankle. (Tr. Trans. p. 38 and 39)

Respondent's IME Dr. George Holmes

Respondent's IME doctor, Dr. George Holmes, was deposed by the parties on January 20, 2020. (See RX 1) Dr. Holmes testified that he felt the mechanism of injury was consistent with the Petitioner's condition. (RX 1 at p. 11, L 16-18) Dr. Holmes also opined that the work accident of 1/22/2019 caused and/or contributed to his current left ankle condition. (RX 1 at p. 13, L 2-9 and p. 32, L 4-9) Dr. Holmes agreed that the 1/31/2019 operation performed on Petitioner's left ankle was to treat, *inter alia*, a syndesmotic disruption. (RX 1, p. 33, L 12-15) As of Dr. Holmes' IME exam of Petitioner on 7/17/2019, Petitioner was unable to perform a single heel rise test secondary to pain. (RX 1, p. 31, L 8-11)

As of Dr. Holmes' examination during his IME on July 17, 2019, Dr. Holmes opined that Petitioner would be limited to standing and walking only 5-15 minutes per hour. (RX 1 at p. 13, L 24 to p.14, L 1-2 and See Exhibit 2 to RX 1, IME Report of 7/17/19 at p. 4)

Dr. Holmes also testified that he felt that all of the medical treatment had been reasonable and necessary up the date of the addendum IME report of 10/8/2019. (RX 1 at p. 13, L 7-9) As of October 8, 2019, Dr. Holmes felt that Petitioner had post-operative stiffness and pain as a result of the left ankle fracture and open reduction internal fixation. (RX 1 at p. 18, L 17-23) Dr. Holmes did testify that he was not critical of Dr. Kadakia for ordering a weight bearing CT Scan since there is evidence that there are times when an orientation of two bones may be different if

one is putting weight on it as opposed if one is not putting weight on it. (RX 1 at p. 20, L 9-15 and p. 22, L 2-5)

On October 8, 2019, Dr. Holmes stated that Petitioner could return to full duty work without seeing him again in spite of his prior restrictions of no standing or walking for more than 5 to 15 minutes that he gave Petitioner on July 17, 2019. (RX 1 at p. 23, L 1-6) Dr. Holmes based his return to work full duty opinion upon the non-weight bearing CT Scan taken on 6/26/2019 only and he did not see the weight bearing CT Scan of 11/5/2019. (RX 1 at p. 23, L 2-6)

On cross-examination during his January 20, 2020 deposition, Dr. Holmes agreed that if the 11/5/2019 CT Scan of the left ankle showed a widening of the syndesmosis, then he would be in agreement with Dr. Kadakia to perform the surgery to repair the syndesmosis itself. (RX 1 at p. 39, L 4-24 and p. 35, L 1-6) Once that opinion was given in the deposition, Respondent had no good faith basis to deny payment of TTD or the second left ankle surgery.

Dr. Kadakia opined that the 11/5/2019 CT Scan of the left ankle showed a subtle malalignment of the syndesmosis which required that the syndesmosis be surgically repaired. (See PX 6 at Dr. Kadakia's 11/12/2019 and 6/9/2020 Notes)

On February 22, 2020, Respondent stopped paying Petitioner TTD as a result of Dr. Holmes' opinions even though Dr. Holmes never saw the 11/5/2019 CT scan results and agreed in his deposition that a second surgery of the syndesmosis would be reasonable if the 11/5/2019 CT showing widening of the syndesmosis. (*See* Request for Hearing Form, Arbitrator's Exhibit 1, at Para. 8)

ISSUES

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

(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
(M) Should penalties or fees be imposed upon Respondent?
(O) Is Petitioner entitled to any Prospective Medical Care?

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

Regarding Issue (F) (Causation)

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

A. DR. PATEL, DR. KADAKIA, DR. HOLMES AND PETITIONER'S TESTIMONY ALL SUPPORT THAT PETITIONER'S LEFT ANKLE INJURY WAS CAUSED BY THE WORK ACCIDENT ON JANUARY 22, 2019

For an injury to be compensable under the Workers' Compensation Act, it generally must occur within the time and space boundaries of the employment. **Sisbro, Inc. v. Industrial Comm'n**, 207 Ill.2d 193, 203, 797 N.E.2d 665 (2003). The "arising out of" component for obtaining compensation under the Workers' Compensation Act is primarily concerned with causal connection; to satisfy that 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.) Claimant need only prove some act or phase of his employment was a causative factor in the ensuing injury to recover benefits under the Act. He need not prove it was the sole causative factor, nor even that it was the principal causative factor of his injury. **Republic Steel Corp. v. Industrial Comm'n**, 26 Ill.2d at 45, 185 N.E.2d at 884 (1962).

Petitioner testified that prior to January 22, 2019, he never injured his left ankle or left foot. (Tr. Trans. p. 24)

Petitioner further testified that on January 22, 2019 at approximately 11:00 a.m. he was washing a commercial refrigerator with soap and water and he got soap in his eye and he started walking toward the bathroom. (Tr. Trans. at p.24-25) Petitioner testified that while he was walking, he slipped on soapy water and he twisted his left ankle and came down with his whole weight onto his left ankle, and he heard a crack in his left ankle. (Tr. Trans. at p. 25) At that time, Petitioner noted a lot of swelling and felt pain in his left ankle. (Id.)

Petitioner testified that after he injured his left ankle on January 22, 2019 he was taken to Northwest Community Healthcare. (Tr. Trans. at p. 26) Petitioner testified that the doctors at Northwest Community Healthcare examined his left ankle, X-rayed it, put on a bandage and gave him crutches. (Tr. Trans. at p. 26) The ER records from Northwest Community Healthcare state

> "The incident occurred at work. The injury mechanism was a twisting injury and fall…Associated symptoms include an inability to bear weight and loss of range of motion."

(Px 1 at p. 6-7)

The X-ray report from the ER at Northwest Community Healthcare states:

> "There are fractures of the medial and posterior malleoli. There is a mild widening of the ankle mortise medially, suggesting underlying ligamentous injury…There is no significant degenerative or erosive injury"

(PX 1 at p. 5)

Clearly the emergency room records at Northwest Healthcare indicate that Petitioner twisted his left ankle at work, was unable to walk and suffered malloleous fractures as a result of the work accident.

On January 23, 2019, Petitioner saw Dr. Narenda Patel at Barrington Orthopedics at the referral of the doctors at Northwest Community Healthcare. (PX 2, Dr. Patel 1/23/2019 Note) On 1/23/2019, Dr. Patel stated in his office note that there was a closed fracture of the medial malleolus with replacement that required surgery to in order repair the left medial malleolus fracture, which Petitioner suffered as a result of the work accident of 1/22/2019 (Id.)

Dr. Holmes testified that he felt the mechanism of Petitioner's left ankle injury was consistent with the Petitioner's condition. (RX 1 at p. 11, L 16-18) Dr. Holmes also opined that the work accident of 1/22/2019 caused and/or contributed to his current condition. (RX 1 at p. 13, L 2-9 and p. 32, L 4-9) Dr. Holmes agreed that the 1/31/2019 operation performed on Petitioner's left ankle was to treat a syndesmotic disruption of the left foot. (RX 1, p. 33, L 12-15)

Based upon the above, the Arbitrator holds that the work injury of January 22, 2019 caused Petitioner's left ankle fracture that he suffered while working in the course of his employment with Respondent.

Regarding Issue J:

Were the Medical Services Reasonable and Necessary, The arbitrator holds the following:

For all the reasons stated above in Issue (F) above, Petitioner suffered a work-related injury to his left ankle on January 22, 2019. As a result of that injury, Petitioner has incurred the following unpaid medical bills:

Providers	Date(s) of Service	Amount of Bill
Alexian Brothers Medical Center	**1/31/2019**	
	$36,321.33 Bill with Balance of…..	**$5,295.53**
ATI Physical Therapy	**4/23/2019 to 7/22/2019 with balance of**	**$4,006.73**
	Total outstanding Medical Bills:	**$9,302.26**

Petitioner had admitted medical bills from Alexian Brothers Medical Center (PX 3B) that had a balance of $5,295.53 and ATI Physical Therapy" bill (PX 5) with a balance of $4,006.73.

Respondent's Benefits Ledger (RX3) demonstrates that Respondent made a partial payment of $14,180.87 on June 3, 2019 to Alexian Brothers, leaving a balance of $5,295.53. (RX3 at p. 3) RX3 also shows that Respondent made payments to ATI Physical Therapy between 5/21/2019 and 7/12/2019, leaving a balance of $4,006.73. (RX3 at p. 3)

Respondent's IME doctor, Dr. George Holmes, testified that all the medical treatment that the Petitioner underwent up to his addendum report of October 8, 2019 was reasonable and necessary and related to the work accident. (RX 1, L 13-18)

Unpaid medical bills that were produced in response to Industrial Commission's subpoena were presumed, under Section 16 of the Workers' Compensation Act, to be certified as true and correct and, thus, were admissible without further foundation for determination of whether to award claimant her incurred medical expenses, given that employer presented no evidence to rebut the presumption. **Shafer v IWCC, 976 Ill. App. 1, 15 (4th Dist. 2011)**

Respondent did not present any UR reports or any other opinions that the petitioner's medical bills were not reasonable and necessary and therefore Respondent failed to rebut the presumption of the certified bills pursuant to Section 16 of the Act.

Based upon the above, the Arbitrator concludes that all of Petitioner's medical charges are reasonable and necessary to attempt to diagnose and cure his left ankle injury and the Arbitrator awards the $9,302.26 of medical bills listed above, as provided in Sections 8(a) and 8.2 of the Act.

Regarding Issue K:

What temporary benefits are in dispute? The Arbitrator finds the following:

Respondent Stopped Paying TTD on 2/18/2020 Based Upon Dr. Holmes' 10/8/2019 IME Report Returning Petitioner to Work Full Duty Even though Dr. Holmes Opined that Petitioner Could only Stand 5 to 15 Minutes in His 7/17/2019 Report After He Actually Examined Petitioner

A claimant is entitled to TTD when a "**disabling** condition is **temporary** and has not reached a permanent condition." **Manis v. Industrial Comm'n,** 230 Ill.App.3d 657, 660, 172 Ill.Dec. 95, 595 N.E.2d 158, 160-61 (1st Dist. 1992) The time during which a claimant is **temporarily totally disabled** is a question of fact for the Commission; and to be entitled to TTD, claimant must prove not only that he did not work but that he was unable to work. **City of**

Granite City v. Industrial Comm'n, 279 Ill.App.3d 1087, 1090, 217 Ill.Dec. 158, 666 N.E.2d 827, 828-29 (5th Dist. 1996). The dispositive test is whether the condition has stabilized, because the Commission reviews the evidence to ascertain whether claimant has reached maximum medical improvement, *i.e.,* the condition has stabilized. **Beuse v. Industrial Comm'n,** 299 Ill.App.3d 180, 183, 233 Ill.Dec. 453, 701 N.E.2d 96, 98 (1998).

Petitioner testified that on January 22, 2019, at approximately 11:00 a.m. he was washing a commercial refrigerator with soap and water and he got soap in his eye and he started walking to the bathroom. (Tr. Trans. at p.24-25) Petitioner testified that while he was walking, he slipped on soapy water and he twisted his left ankle and came down with his whole weight onto his left ankle, and he heard a crack in his left ankle. (Tr. Trans. at p. 25) At that time, Petitioner noted a lot of swelling and felt pain. (Id.)

Respondent paid Petitioner his TTD from the date of the accident, January 22, 2019 to February 18, 2020 when Respondent stopped paying TTD. (See Arb. Exhibit 1 and Arb. Exhibit 3 and RX 3, Respondent's Payment Ledger)

In this case, Respondent argues that it properly refused to pay TTD based upon Dr. Holmes IME reports and deposition opinions that Petitioner could return to full duty. (See RX 4 Respondent's Response to Penalties and RX1 Dr Holmes Deposition and IME Reports)

Dr. Holmes, however, had stated in his 7/17/2019 IME Report after examining Petitioner that Petitioner could only stand or walk for 5 to 15 minutes per hour as a result of his severe left ankle fracture. (RX 1 at p. 13, L 24 to p.14, L 1-2 and See Exhibit 2 to RX 1, IME Report of 7/17/19 at p. 4

Dr. Holmes opined in his IME Addendum report of 10/8/2019 that Petitioner could return to full duty work without further examining Petitioner even though Petitioner's condition stayed the same according to Dr. Kadakia. (RX 1, Exhibit 3 to Dr. Holmes Deposition) Further Dr. Holmes only reviewed four of Dr. Kadakia's office notes and the 6/26/2019 CT Scan in reaching that conclusion. Dr. Holmes therefore had no basis for his opinion that Petitioner could return to work full duty since he never examined Petitioner again and none of Dr. Kadakia's medical records showed that he was improving in any way.

An expert's opinion is only as valid as the reasons or basis for the opinion. **Inman v Howe Freightways,** 130 N. E.3d 458, 500 (1st Dist. 2019); **Berke v Manilow**, 63 N.E. 3d 194, (1st Dist. 2016). As such, the party must lay a sufficient foundation to establish the reliability of the reason for the expert's opinion. **Inman v Howe Freightways**, 130 N.E.3d 500. Without the basis, the expert's opinion amounts to sheer speculation. **Id**.

Dr. Holmes had no basis for his opinion that Petitioner could return to work full duty after stating three months earlier that it was his opinion that Petitioner could only walk or stand for 5 to 15 minutes per hour.

In addition, on November 12, 2019, after reviewing the weight bearing CT Scan of the left foot that Dr. Holmes never saw, Dr. Kadakia stated that there was a subtle malalignment of the syndesmosis and that he recommended a surgery to remove the hardware and to reconstruct the deltoid and syndesmosis. (PX 6 at Dr. Kadakia 11/12/2019 Note) Dr. Kadakia again placed Petitioner off work until further evaluation. (Id.)

In his deposition of January 20, 2020, Dr. Holmes agreed that if the 11/5/2019 CT Scan of the left ankle showed a widening of the syndesmosis, then he would be in agreement with Dr. Kadakia to perform the surgery to repair the syndesmosis itself. (RX 1 at p. 39, L 4-24 and p. 35, L 1-6) Since Dr. Holmes agrees that Petitioner needs a surgery to repair the syndesmosis of the left ankle, Petitioner's medical condition has not yet stabilized and Respondent should have authorized the surgery and paid TTD. See **Beuse v. Industrial Comm'n,** 299 Ill.App.3d 180, 183, 233 Ill.Dec. 453, 701 N.E.2d 96, 98 (1998)

The Arbitrator holds, for the reasons stated in the "Causation" and "TTD" sections and based on all testimony and medical evidence, that Petitioner is awarded TTD benefits from February 19, 2020 to July 27, 2020, the trial date, or 23 weeks, times a TTD rate of $432.84 for a total of $9,955.32 of TTD owed up to the time of trial on July 27, 2020.

Regarding Issue M:

Whether Penalties should be awarded for Respondent's unreasonable refusal to Pay TTD or Reasonable and Necessary Medical Bills, the Arbitrator holds the following:

Penalties and attorneys fees are denied.

Regarding Issue O:

Is Petitioner entitled to any Prospective Medical Care?

Dr. Kadakia Opined Petitioner Required the Revision Surgery of the Syndesmosis To Be able to Return to Work and Dr. Holmes Agreed that IF there was Widening On thw 11-5-2019 CT Scan, Revision Surgery Would Be Needed

The opinion of workers' compensation claimant's physician, which Industrial Commission found to be more persuasive than that of employer's physician, supported Commission's determination that lumbar surgery prescribed for claimant by her physician, but not yet performed, was reasonable and necessary, thus supporting award requiring employer to

pay for surgery, despite employer's contention that objective diagnostic tests supported its physician's opinion rather than that of claimant's physician. **Plantation Manufacturing v Industrial Commn**, 294 Ill.App.3rd 705, 691N.E.2d 13 (2d Dist. 1998)

Petitioner's first treating doctor, Dr. Narenda Patel opined that Petitioner would require a left ankle revision surgery to remove the plate and seven screws in July 2019. (See PX 2, Dr. Patel 5/1/2019 Note) Petitioner's second treating surgeon, Dr. Anish Kadakia also opined that Petitioner would require a left ankle revision surgery to remove the plate and screws as well as a reconstruction of the left foot and left gastroc, which is necessary as a result of the work injury of January 22, 2019. (PX6, Dr. Kadakia's 7/19/2019 and 6/9/2020 Notes).

Dr. Holmes opined in his IME addendum report of 10/8/2019 stated that he did not agree that petitioner would get any significant pain relief from removal of the medial hardware, synovectomy, arthrotomy, and removal of scar tissue and gastroc recession. (RX 1, Exhibit 3 to Dr. Holmes Deposition at p. 3, in response to #1E) However, Dr. Holmes did not opine that Petitioner would not benefit from a revision of the misalignment of the syndesmosis. Also, the majority of the hardware is on the outside of Petitioner's left ankle and Dr Holmes artfully stated that Petitioner would not get pain relief from removal of the medial hardware. (See PX9, X-Ray Photo of Petitioner's Left Ankle)

On November 12, 2019, Dr. Kadakia reviewed the weight bearing CT Scan of the left foot that Dr. Holmes never saw, and Dr. Kadakia opined that there was a subtle malalignment of the syndesmosis and that he recommended a surgery to remove the hardware and to reconstruct the deltoid and syndesmosis. (PX 6 at Dr. Kadakia 11/12/2019 Note)

In his deposition, Dr. Holmes agreed that if the 11/5/2019 CT Scan of the left ankle which he never reviewed showed a widening of the syndesmosis, then he would be in agreement with Dr. Kadakia to perform the surgery to repair the syndesmosis itself. (RX 1 at p. 39, L 4-24 and p. 35, L 1-6)

> Q So moving on to if Dr. Kadakia in November (2019) after reviewing a weight bearing CT found slight widening of the syndesmosis, and he found that to be an anatomic explanation for the pain complaints of Mr. Espana at that time, would you agree based upon the history that that would be a reasonable basis for Dr. Kadakia to recommend the surgery he's outlined in the past?
>
> A Given your hypothetical part of the surgery, yes.

RX 1, Dr. Holmes' Deposition, Page 39, Lines 4-13

> Q Which would you agree with, the fixation of the syndesmosis?
>
> A Given the hypothetical, given that I have not reviewed the MIR -- sorry, the CT scan

myself, assuming that's accurate, yes, sir.

RX 1, Dr. Holmes' Deposition, Page 40, Lines 2-6

> Q Okay. But you'd agree it's not unreasonable to attempt to improve the function of his left foot and ankle, correct?
>
> A It's never not unreasonable to try to improve a patient's functional outcome. Again, given the hypothetical you've given me, I can't make any further comments with regard to the feasibility for this gentlemen having not reviewed the CT scan myself.

RX 1, Dr. Holmes' Deposition, Page 43, Lines 8-16

Dr. Holmes agreed with the need for the second surgery on the syndesmosis, which is one of the basis of Dr. Kadakia's recommendation for the surgery. In addition, Petitioner indicated that the lateral hardware was causing him a lot of pain and Dr. Kadakia's plan to surgically remove the hardware is likely to reduce Petitioner's pain and increase his function.

Based upon Dr. Kadakia's left ankle surgery recommendation in November 2019 and thereafter and Dr. Holmes' concession that he agreed with need for the left ankle surgery to repair the syndesmosis, the Arbitrator should award the second left ankle surgery.

The Arbitrator awards the left ankle revision surgery and holds that Respondent shall authorize the Petitioner's left ankle surgery since the surgery is reasonable, necessary and was caused by the work injury of January 22, 2019. Further the Arbitrator orders that that Respondent shall also authorize all post-surgery physical therapy and other related post-surgical medical treatment as provided in Section 8(a) of the Act.

CONCLUSION

Causation

The Arbitrator finds that Petitioner's left ankle injury was caused by the work injury of January 22, 2019 based upon the testimony of Petitioner and the medical records of Dr. Narendra Patel and Dr. Anish Kadakia, as well as Dr. Holmes' opinion that the left ankle injured was caused by the work accident of January 22, 2019.

Medical Benefits

Petitioner's medical bills were admitted as Petitioner's Exhibits 3B, and 5. The Arbitrator awards the medical bill from Alexian Brothers Medical Center in Exhibit 3B in the amount of $5,295.53 and the bill of ATI Physical Therapy in Exhibit 5 in the amount of $4,006.73. The

Respondent shall pay the reasonable and necessary medical services of **$9,302.06** as provided in Section 8(a) and 8.2 of the Act.

Temporary Total Disability and Credit for TTD Paid

Respondent shall pay Petitioner temporary total disability benefits of $432.84 per week for 78 and 6/7ths weeks, commencing on January 22, 2019 to the date of trial, July 27, 2020 as provided in Section 8(b) of the Act. Total TTD owed is $34,133.77, minus a credit for TTD paid of $24,239.04 leaving **$9,894.73 in TTD due and owing** to Petitioner.

Penalties

Penalties and attorneys fees are denied.

Prospective Medical Care

Petitioner's first treating doctor, Dr. Narenda Patel opined that Petitioner would require a left ankle revision surgery to remove the plate and seven screws in July 2019. (See PX 2, Dr. Patel 5/1/2019 Note) Petitioner's second treating surgeon, Dr. Anish Kadakia also opined that Petitioner would require a left ankle revision surgery to remove the plate and screws as well as a reconstruction of the left foot and left gastroc, which is necessary as a result of the work injury of January 22, 2019. (PX6, Dr. Kadakia's 7/19/2019 and 6/9/2020 Notes).

Respondent's IME Doctor, Dr. George Holmes, testified that he did not believe Petitioner would benefit from a second left foot surgery. (RX1, Dr. Holmes deposition, p. 24, L 17-20) Dr. Holmes did not see the weight bearing CT Scan of the left foot taken on 11/5/2019. (RX1, Dr. Holmes deposition, p. 40, L 4-6)

Dr. Holmes testified that if Dr. Kadakia found widening of the syndesmosis, he would agree with a fixation surgery of the syndesmosis of Petitioner's left ankle. (RX1, Dr. Holmes deposition, p. 40, L 2-6)

The Arbitrator finds that Petitioner has demonstrated, through the medical records of Dr. Anish Kadakia and the weight bearing CT of the left ankle that the left ankle hardware removal and repair of the syndesmosis repair is reasonable and necessary. Based on Dr. Kadakia and Dr. Holmes' opinions, this revision surgery would be reasonably related to the work accident of January 22, 2019.

Based on the foregoing medical records and opinions, the Arbitrator awards the Petitioner the prospective medical care in the form of the left ankle revision surgery recommended by Dr. Kadakia and any other post-surgical care treatment, including but not limited to, physical therapy.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC036769
Case Name	HEDMAN, ERIC J v. CITY OF ELMHURST
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0409
Number of Pages of Decision	13
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Thomas Duda
Respondent Attorney	Daniel Artman

DATE FILED: 8/11/2021

/s/ Kathryn Doerries, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERIC J. HEDMAN,

Petitioner,

vs. NO: 14 WC 36769

CITY OF ELMHURST,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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.

August 11, 2021

o- 8/10 /21
KAD/jsf

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEDMAN, ERIC
Employee/Petitioner

Case# **14WC036769**

CITY OF ELMHURST
Employer/Respondent

On 1/23/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0728 LAW OFFICES OF THOMAS W DUDA
CHRISTINA
30 W COLFAX
PALATINE, IL 60067

0075 POWER & CRONIN LTD
DANIEL ARTMAN
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

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

ERIC HEDMAN
EMPLOYEE/PETITIONER
v.
CITY OF ELMHURST
EMPLOYER/RESPONDENT

CASE # 14 WC 36769

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **October 18, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

Disputed Issues

☐ 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 17, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$84,984.64**; the average weekly wage was **$1,634.62**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$0.00** 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 under Section 8(j) of the Act.

Order

Because Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries or was exposed to an occupational disease on October 17, 2013 and further failed to prove that his condition of ill-being was causally connected to accident or exposure of his employment with Respondent, Petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

January 22, 2020
Date

ICArbDec p. 2

JAN 23 2020

Statement of Facts

This matter was heard on October 18, 2019 and proofs were closed. Following the close of proofs, Petitioner filed an Election of Award under Section 8(d)2 on November 26, 2019. Petitioner's Application for Adjustment of Claim (Arb. Ex. 2) notes this matter was filed under the Occupational Diseases Act.

Petitioner Eric Hedman testified that he was employed by Respondent City of Elmhurst Fire Department beginning in July 1994. He was hired as a firefighter. He eventually performed the duties of firefighter, emergency medical technician ("EMT") and training officer. Before being hired by the Respondent, Petitioner worked for the Village of Roselle as a full time firefighter and EMT between 1991 and July of 1994. While working for Roselle, Petitioner worked 16 hour shifts, 3 days a week, during which he lived, ate and slept at the station. Before working at the Village of Roselle he was a volunteer firefighter for the Yorkville Fire Protection District. As a volunteer firefighter he was given a pager and would report to the station on short notice.

During his career, the Petitioner engaged in very heavy strenuous activities which included fire suppression, vehicle extrication and ambulance/emergency medical technician services. In performing fire suppression duties, Petitioner, while wearing heavy bunker gear, would engage in very heavy activities. The bunker gear added approximately 20 pounds to his body weight and when he would wear a self-contained breathing apparatus ("SCBA") that would add an additional 45 pounds of weight. While wearing this equipment in extremes of heat and cold, he would be pulling large diameter hose from the top of an engine and arrange it to be pulled into the burning structure. The hose weighed tens of pounds when dry and hundreds of pounds when "charged". Petitioner had to carry and use tools including an axe, pike pole and chainsaw. He would be required to carry ladders up to 36 foot extension ladders and to climb ladders to either rescue someone from an upper story or ventilate the roof. While climbing the ladder he would be carrying tools and equipment such as a chainsaw weighing 40 pounds. His time on scene varied from as short as 15 to 20 minutes to several hours. He also performed emergency medical duties that involved responding to life-threatening medical emergencies in which he would render first aid, perform CPR, and then physically pick up the victim, carry him/her to the ambulance, and transport the victim to the hospital. Lifting the victim involved placing the victim on a cot which had weight, plus the weight of the patient ranging between 90 pounds and 400 pounds. As a first responder, Petitioner would perform extrication duties at an accident scene in which he would use hydraulic equipment to remove the patient from the vehicle and then lift the patient from the accident scene and place him/her on a cot and carry the patient to the ambulance. Petitioner admitted the Respondent's job description for a firefighter as PX 3.

During his employment at Yorkville, Roselle, and Elmhurst, the Petitioner always was under the care of a primary care physician and was never treated for any heart conditions and was never referred to a cardiologist. Throughout his career, he had no cardiovascular symptoms. He was active and exercised on a regular basis without shortness of breath, chest discomfort or lightheadedness. At the time he was hired by the Village of Roselle, he was required to undergo a physical examination performed at Alexian Brothers Medical Center. This was a general physical examination that included a cardiac stress test. He passed all of the physical examination requirements without incident. When he was first hired by Respondent, he underwent a physical examination at Elmhurst Hospital that included blood work, EKG and another cardiac stress test. He passed this examination. Petitioner was required to submit to periodic physical examinations which changed in character over time. PX 5 is the physical exam report dated 4/22/00 finding Petitioner can perform the essential job functions. The early exams were required by an agency known as the National Fire Protection Association ("NFPA") to qualify him to use a respirator. The examinations became more thorough. An EKG would be part

of the examination process. In April 2010, Petitioner underwent an echocardiogram stress test. Dr. Bonow testified it showed left ventricular hypertrophy (PX 10, p 15). Petitioner testified that he was not advised of any abnormality in the 2010 echocardiogram stress test. PX 4 cleared Petitioner to perform his essential job functions on 9/7/11.

Petitioner testified he had an annual physical examination in October 2013 at Respondent's direction at Elmhurst Hospital Occupational Health. On October 10, 2013, a stress echo test was performed. The results were found to be abnormal. It revealed severe global left ventricular hypertrophy, stress induced hypokinesis in the basal septum and portion of the inferior wall. Stress EKG was normal (PX 6). Petitioner testified that he saw Dr. Vitale on October 16, 2013. He testified that he was advised that the results were normal. He then had a conversation with Dr. Vitale who advised his there was a problem with his heart, and he needed to be cleared by a cardiologist. Dr. Vitale called the Petitioner at home advising him to come to the Occupational Health Center. At that meeting, Dr. Vitale assigned him light duty. Petitioner testified he went to his primary care physician who provided him a series of names and he went to Dr. George Nijmeh.

Dr. Nijmeh saw the Petitioner on October 24, 2013. Petitioner advised him he gets yearly stress tests. For years he has been told he had an abnormal stress test, but he has always had normal exercise treadmill EKGs. This year he was told the stress echo was abnormal due to thickening of the heart muscle. He denied chest pain, palpitations, shortness of breath or syncope. Dr. Nijmeh scheduled a nuclear stress test and a two dimensional echocardiogram. He also discussed a cardiac MRI. He was suspicious for hypertrophic cardiomyopathy (PX 6). The October 25, 2013 nuclear stress test impression was normal (RX 7). The November 4, 2013 echocardiogram demonstrated a hypertrophied left ventricle and a significantly thickened ventricular septum (PX 8). On November 15, 2013, Dr. Nijmeh discussed the diagnosis of hypertrophic cardiomyopathy. Dr. Nijmeh also scheduled a cardiac MRI and referred Petitioner to Dr. Bonow who specializes in HCM (PX 6). The November 21, 2013 MRI found severe hypertrophic cardiomyopathy asymmetrically involving the left ventricle. The MRI demonstrated the interventricular septum reaching a diastolic thickness of 30 mm with an elevated septal-inferolateral diastolic thickness ratio of 4:1. The test showed no discreet regional left ventricular wall motion abnormality, but it did demonstrate a dynamic left ventricular outflow track obstruction (PX 8, p 13).

Petitioner was seen by a Dr. McKiernan at Loyola University for a second opinion on November 22, 2013 (PX 7). Dr. McKiernan notes Petitioner's yearly stress tests were normal and commented on concentric LVH and Athlete's heart. Petitioner reported he was asymptomatic. McKiernan notes the stress echo was non obstructive. He diagnoses HOCM (hypertrophic obstructive cardiomyopathy) and advises Petitioner to avoid strenuous activity (PX 7).

On December 11, 2013, Dr. Bonow described the Petitioner as active and healthy. He has no symptoms (PX 8). He notes Petitioner's father is known to have HCM. He reviewed the diagnostic testing performed. He notes the echocardiogram and MRI finding septal thickness greater than 30 mm. He stated he would discuss return to duty with Dr. Vitale (PX 8). Petitioner testified he was returned to duty on January 2, 2014. Petitioner saw Dr. Greenstein on February 26, 2014 (PX 6). He was asymptomatic. He reported his father had 1.8 cm thick ventricle. Dr. Greenstein reviewed the diagnostics and noted a Holter found PVC, one couplet, no runs of NSVT. Dr. Greenstein noted deferral to Dr. Bonow about work limitations. He discussed an ICD, but Petitioner chose to defer this. Dr. Greenstein reinforce the importance of avoiding strenuous activity (PX 6). Petitioner underwent a Holter monitor on July 11, 2014. There were 4 couplets and an 8 beat run with 86 premature atrial contractions and a 9 beat run of tachycardia. No symptoms were reported (PX 6). Petitioner saw Dr. Ross on July 15, 2014. He strongly recommended the ICD (PX 6). Petitioner saw Dr. Bonow on July 18, 2014. He discussed the ICD in light of the severe nature of the hypertrophy (PX 8). Petitioner saw Dr. Greenstein on

September 10, 2014 for ICD evaluation. He denied any symptoms. He stated that if he gets the ICD, he will not be able to work. He is looking for other employment (PX 6).

Petitioner had his annual physical on November 4, 2014 (PX 9). He was found fit for duty, but final clearance is pending. The Elmhurst records note telephone exchanges between the office and Petitioner to obtain paperwork from his cardiologist to complete his fitness for duty assessment. Dr. Bonow provided a December 19, 2014 letter to Dr. Galassi stating Petitioner has severe hypertrophic cardiomyopathy. Although he is asymptomatic, the stresses of a firefighter are detrimental. Dr. Galassi spoke with Dr. Bonow on December 23, 2014 and was advised of the recommendation for ICD. Dr. Bonow stated further testing will not add anything. On December 23, 2014, Dr. Galassi found Petitioner not fit for duty (PX 9). Petitioner testified he stopped working on December 16, 2014. At no time during his employment with Respondent did he have any type of cardiac event.

Petitioner testified he applied for his disability pension. He underwent surgery to implant the ICD in April 2015. He testified that the city refused to allow him to return to work with the ICD. He found work in December 2015 with the CTA as a safety trainer. His salary was $54,000. He left in March 2016 to become safety manager for Edwards Engineering until September 2017 when he became regional safety superintendent for Asplundh Tree Experts. He left in February 2019 because the job became too stressful. His blood pressure was starting to elevate. He went to work for Naperville as a safety trainer. His current salary is $75,000. The ICD pacemaker function has never been utilized for him. It will need to be replaced in 2023.

Dr. Bonow authored multiple letters to Petitioner's attorney (PX 10, Ex 1-4) and testified by evidence deposition taken November 18, 2016 (PX 10). He testified that he is board certified in cardiology and is a professor of medicine in the field of cardiology. He has written many articles on hypertrophic cardiomyopathy . He testified to his referral of Petitioner and the records and diagnostics ordered and reviewed including the EKG and MRI. He opined that Petitioner had HCM. He did not believe that there was an obstructive component. He notes Petitioner's family history. Petitioner had no symptoms or obstructive component to his condition, so no treatment was recommended. He was at risk for sudden cardiac death, so monitoring was suggested. Septum of greater than 30 mm indicates high risk individuals and is an indication for implanted cardiac defibrillator (ICD). Petitioner had a 24 hour Holter monitor that did not show fast rhythms. Petitioner has a July 2014 Holter monitor that did show ventricular tachycardia. Dr. Bonow discussed the ICD (PX 10).

Dr. Bonow reviewed PX 10, Ex 1, where he stated that "Although his occupation cannot be considered the cause of this condition, the environmental exposures of his occupation including heat, smoke and stress, clearly have a potential to aggravate that condition." He explained that the exposure does not cause the condition or makes the muscle thicker. It is going to impair the way the heart functions. Dr. Bonow also reviewed PX 10, Ex 2 and PX 10, Ex 4. In those reports he stated that environmental exposures have the potential to aggravate the condition including the risk of sudden death or incapacitation. He cannot provide evidence that Petitioner is disabled as a consequence of an on-the-job injury (PX 10, Ex 2). There is no evidence that training or weightlifting will increase the magnitude of the hypertrophy. The possible aggravating factors of firefighting is that it could trigger lethal arrythmias (PX 10, Ex 4).

Dr. Bonow testified that hypertrophic cardiomyopathy is genetic. He cannot identify an environmental factor to a reasonable degree of medical certainty. Petitioner's duties as a firefighter were not a contributing factor resulting in his disability. They did not cause the muscle to get thicker. The environment of a firefighter could put him at risk in the future. His job did not cause the condition or make the condition worse. He is not disabled because of any physical limitation. It is disabling because the physicians are telling him he should not do this job given the diagnosis made (PX 10).

Dr. Richard Carroll provided a record review and opinions dated April 5, 2015 (RX 1). He reviewed medical records including Dr. Bonow's December 19, 2014 correspondence to Petitioner's attorney. He opined that Petitioner's occupation as a firefighter did not cause or contribute to his underlying condition of hypertrophic cardiomyopathy. He stated that his interpretation of Dr. Bonow's letter is that the occupational activities did not worsen or change the underlying condition, but Petitioner is at risk that because of his condition, activities could precipitate sudden cardiac death (RX 1).

Dr. Samo testified by evidence deposition taken March 20, 2018 (RX 4). He testified he is board certified in emergency medicine. He examined Petitioner on August 19, 2015. He reviewed medical records and diagnosed hypertrophic cardiomyopathy with an ICD. He opined that Petitioner was not fit for duty due to the risk of sudden incapacitation. He opined that Petitioner's hypertrophic cardiomyopathy was not caused, exacerbated or contributed to by his duties as a firefighter. The condition is idiopathic or genetic (RX 4).

Dr. Timothy McDonough testified by evidence deposition taken April 4, 2018 (RX 5). He testified he is board certified in internal medicine, cardiovascular disease and interventional cardiology. He examined Petitioner on August 13, 2015 including review of records. He testified Petitioner was diagnosed with hypertrophic cardiomyopathy without significant outflow obstruction. This is a genetic condition. Petitioner could perform full and unrestricted duties but with risk of sudden cardiac death. He opined that service as a firefighter did not cause of exacerbate the condition. It contributed to an increased risk of continuing to perform his duties (RX 5).

Petitioner's application for disability pension was heard by the Pension Board. On February 6, 2019 the Board entered its decision detailing the evidence including the medical records, Petitioner's testimony and the evidence depositions of Dr. Bonow, Dr. Samo and Dr. McDonough. The Board denied the application for a line of duty pension finding that the Petitioner failed to establish a causal connection between an act of duty or the cumulative acts of duty and his condition of hypertrophic cardiomyopathy (RX 8). Petitioner has filed a complaint for administrative review of this decision in the Circuit Court of DuPage County (PX 11). There has been no decision as of the date of trial in this matter.

Conclusions of Law

As a preliminary matter, the parties have argued the res judicata or collateral estoppel effect, if any, of the Pension Board Decision. The Pension Board denied the application for a line of duty pension finding that the Petitioner failed to establish a causal connection between an act of duty or the cumulative acts of duty and his condition of hypertrophic cardiomyopathy. Collateral estoppel, a branch of res judicata, prohibits the relitigating of an issue actually decided in an earlier proceeding between the same parties. *McCulla v. Industrial Commission*, 232 Ill. App. 3d 517, 520, 597 N.E.2d 875, 173 Ill. Dec. 901 (1992). In order to apply collateral estoppel, (1) the issue decided in the prior adjudication must be identical to the issue in the current action; (2) the party against whom estoppel is asserted must have been a party or in privity with a party in the prior action; and (3) the prior adjudication must have resulted in a final judgment on the merits. *Dowrick v. Village of Downers Grove*, 362 Ill. App. 3d 512, 516, 840 N.E.2d 785, 298 Ill. Dec. 672 (2005). We see no meaningful difference between the "line of duty" standard in PEDA and the causation test in workers' compensation claims—that the injury "arose out of and in the course of employment." *Mabie v. Village of Schaumburg,* 364 Ill. App. 3d 756; 847 N.E.2d 796; 2006 Ill. App. LEXIS 259; 301 Ill. Dec. 786 (1st Dist. 2006). The Arbitrator further notes that the Pension Board decision was based upon lack of medical causation, which is an identical issue. The decision therefore meets the first criteria. The party against whom the estoppel is asserted is the Petitioner, thereby satisfying the second criteria. However, the decision is not final, as it is currently on appeal in the courts, failing the third criteria necessary to apply collateral estoppel.

In support of the Arbitrator's decision with respect to © Accident/Last Exposure and (F) Causal Connection, the Arbitrator finds as follows:

Petitioner is seeking compensation claiming that he suffered an occupational disease while employed by Respondent as a firefighter. He had no episode of symptoms during his job duties or any specific event. He was diagnosed with hypertrophic cardiomyopathy. He underwent implantation of a cardiac defibrillator and was found unfit to continue his duties as a firefighter. The claimant in an occupational disease case has the burden of proving that he suffers from an occupational disease and that a causal connection exists between the disease and has employment. *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467, 748 N.E.2d 339, 254 Ill. Dec. 893 (2001).

Section 1(d) of the Workers' Occupational Diseases Act ("OD Act"), states, in part:
"In this Act the term 'Occupational Disease' means a disease arising out of and in the course of the employment, or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. 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 need 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."
It is undisputed that Petitioner worked as a firefighter and has been a firefighter/EMT and firefighter/paramedic for Respondent since 1994. His duties included fire suppression, responding to emergency calls, fire, EMS, auto accident calls. Petitioner's testimony described his duties during fire suppression, accident extrication and emergency medical services, very strenuous activities. Petitioner testified that he performs this strenuous work while wearing heavy, insulated personal protective equipment ("PPE") in extremes of heat and cold. The medical evidence and opinions all agree that Petitioner has hypertrophic cardiomyopathy and is now not fit to perform his regular duties, due to the risk that exertive physical activities could cause sudden cardiac death. Petitioner denied any particular event or injury. He denied any symptoms prior to his diagnosis including chest pain, palpitations, shortness of breath, dyspnea or other cardiovascular symptoms.
Petitioner initially raises the rebuttable presumption for firefighters to establish causal connection. The provisions of 820 ILCS 310/1(d) relating to a rebuttable presumption reads as follows:
"Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), emergency medical technician-intermediate (EMT-I), advanced emergency medical technician (A-EMT), or paramedic which results directly or indirectly from any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT, EMT-I, A-EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, EMT-I, A-EMT, or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission."

Petitioner has the necessary 5 years to qualify for the application of this presumption. The application of the statutory presumption has been addressed in *Johnston v. IL Workers' Comp. Com.*, 2017 IL App 160010WC, 80 N.E2d 573 (2d Dist. 2017) and *Simpson v. IL Workers' Comp. Com.*, 2017 IL App 160024WC, 79 N.E2d 643 (3d Dist. 2017). The Occupational Disease provision has been interpreted the same as the WC provision in *Ekkert v. Ill. Workers' Comp. Comm'n*, 2018 IL App (2d) 170447WC-U ; 2018 Ill. App. Unpub. LEXIS 2005 (2nd Dist., 2018). *Johnston* held that this presumption was a bursting-bubble presumption. *Johnston*, 2017 IL App (2d) 160010WC, ¶ 37. That is, the presumption places a burden on an employer to come forward with some evidence to negate it. Id. Once the employer does so, the presumption vanishes, and the trier of fact must then address the evidence as if the presumption never existed. Id. The ultimate burden of persuasion remains with the claimant. Id. ¶ 36 (quoting *Diederich*, 65 Ill. 2d at 100-01). Furthermore, this is not a "strong" presumption. It does not require a Respondent to come forward with some heightened quantum of evidence, such as clear and convincing. Id. Rather, it simply requires "the employer to offer some evidence sufficient to support a finding that something other than claimant's occupation as a firefighter caused his condition." (Emphasis in original.) It is not necessary for an employer to present evidence eliminating occupational exposure as a cause of a claimant's condition of ill being. Id. ¶ 51. It is sufficient to rebut the presumption if "the employer introduces some evidence of another potential cause of the claimant's condition." *Simpson*, 2017 IL App (3d) 160024WC, ¶ 46. Once rebutted, the Commission is free to resolve any factual dispute as it would in an ordinary workers' compensation case, without reference to the presumption. Id.

Respondent offered report of Dr. Richard Carroll and the testimony of Dr. Daniel Samo and Dr. Timothy McDonough who opined that Petitioner's firefighter activities did not cause or contribute to hypertrophic cardiomyopathy. His condition was genetic and idiopathic. Based upon the standard as set in *Johnston* and *Simpson*, Respondent has presented sufficient evidence to fulfill its burden of production and rebut the presumption. Finding the presumption to be successfully rebutted, the Arbitrator must weigh the evidence to determine whether Petitioner has proven by a preponderance of the evidence that his coronary artery disease was causally related to his occupational exposures.

Respondent presented the testimony Dr. Samo and Dr. McDonough, and the report of Dr. Carroll. Dr. Samo opined that Petitioner was not fit for duty due to the risk of sudden incapacitation. He opined that Petitioner's hypertrophic cardiomyopathy was not caused, exacerbated or contributed to by his duties as a firefighter. The condition is idiopathic or genetic. Dr. McDonough testified Petitioner was diagnosed with hypertrophic cardiomyopathy without significant outflow obstruction. This is a genetic condition. He opined that service as a firefighter did not cause of exacerbate the condition. It contributed to an increased risk of continuing to perform his duties.

Dr. Bonow agreed that the Petitioner's condition was not caused by his firefighting activities. It is a genetic condition. The duties did not increase the thickening on the muscle or make the condition worse. He testified that the condition could be aggravated by the duties, but explained that he was stating that exertion could trigger an arrythmia, causing sudden cardiac death. Dr. Carroll reviewed medical records including Dr. Bonow's December 19, 2014 correspondence. He opined that Petitioner's occupation as a firefighter did not cause or contribute to his underlying condition of hypertrophic cardiomyopathy. He stated that his interpretation of Dr. Bonow's letter is that the occupational activities did not worsen or change the underlying condition, but Petitioner is at risk that because of his condition, activities could precipitate sudden cardiac death.

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.

Having heard the testimony and reviewed the exhibits in this matter, the Arbitrator finds that the persuasive medical evidence supports that Petitioner's condition of ill being was not caused, aggravated, exacerbated or contributed to by his duties as a firefighter. Dr. Samo, Dr. McDonough and Dr. Carroll agree. Dr. Bonow does not provide any testimony that the condition was worsened by the work exposures. He agrees it was not caused by his work duties and that those duties did not increase the thickness of the heart muscle or accelerate any progression of the condition. The Arbitrator agrees with Dr. Carroll's interpretation of his testimony. The Petitioner, who has had no episodes of work related symptoms and no symptoms at all, is at risk of a possible sudden cardiac episode by stresses to his body by dehydration, exertion or exposure. This does not meet the definition of an occupational disease.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he was exposed to an Occupational Disease on October 17, 2013 or that his condition of ill-being of hypertrophic cardiomyopathy is causally connected to his employment with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary Compensation, and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident/Exposure and Causal Connection, the remaining issues of Notice, Medical, Temporary Compensation and Nature & Extent are moot.

Petitioner's claim for compensation is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC037232
Case Name	MCDONOUGH,PATRICK v. CITY OF CHICAGO
Consolidated Cases	13WC037546
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0410
Number of Pages of Decision	5
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Michael Greco
Respondent Attorney	Aukse Grigaliunas

DATE FILED: 8/12/2021

/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

Patrick McDonough,

Petitioner,

vs.

No. 11 WC 37232,
(Consolidated w/ 13 WC 37546)

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the record and reviewing the Arbitrator's June 20, 2019 order denying Petitioner's Petition to Reinstate claim number 11 WC 37232, hereby affirms the Arbitrator's order.

Findings of Fact:

On September 27, 2011, Petitioner filed an Application for Adjustment of Claim, 11 WC 37232, in which he alleged sustaining injuries to the man as a whole while working on July 30, 2011. On November 14, 2013, Petitioner filed his second Application for Adjustment of Claim, 13 WC 37546, in which he alleged sustaining injuries to his left leg, back, neck, and man as a whole while working on September 17, 2013. On April 8, 2016, an Order granting consolidation of the two claims was entered.

Petitioner's claims were given "final" trial dates by the Arbitrator on multiple occasions, and were dismissed when Petitioner failed to appear. Petitioner's claims have been dismissed for want of prosecution a total of four times, on: April 17, 2015, February 1, 2016, June 7, 2018, and

February 27, 2019.[1] The first three dismissals were vacated and Petitioner's claims were reinstated. This Review concerns Petitioner's fourth dismissal entered on February 27, 2019, and his subsequent Petition to Reinstate Case, which the Arbitrator denied on June 20, 2019.

Since 2016, both of Petitioner's claims have been on file for three or more years. The Arbitrator had set May 21, 2018 as one of several final trial dates. On May 21, 2018, counsel for both parties and the Petitioner appeared before the Arbitrator, but the trial did not proceed. Instead, the parties engaged in an hours-long pretrial conference with the Arbitrator, and all present agreed that the trial would begin on another specially set date of June 7, 2018. The Arbitrator also set a second agreed upon date of June 28, 2018, to, "ostensibly close proofs."

Petitioner did not appear on June 7, 2018. A record was made of that proceeding. The Arbitrator reported on the record that on May 21, 2018, Petitioner had made it clear that he wanted to proceed with his case, and that, "it was agreed by everyone that we would appear on today's date, June 7th, for a specially set trial where Petitioner would testify." The Arbitrator further noted that Petitioner "readily agreed to that."

Petitioner's reported reason for not appearing on June 7, 2018 was that he claimed to have obtained a note dated May 30, 2018 from his psychiatrist, Dr. Pundy, which indicated he was not psychologically able to testify. The Arbitrator stated that he had gone to great lengths to accommodate Petitioner. The Arbitrator noted that Petitioner waited almost one week after receiving Dr. Pundy's May 30, 2018 note before informing the Arbitrator and his attorney of it, or of his intention to not testify on June 7, 2018. The Arbitrator noted that Petitioner never requested a continuance of the June 7, 2018 hearing. The Arbitrator stated he did not place much weight upon Dr. Pundy's note, because no accompanying treating records or deposition testimony of that doctor were offered. The Arbitrator then entered an order dismissing Petitioner's claims for want of prosecution.

Petitioner filed a timely Petition to Reinstate his claims on July 17, 2018. That Petition was continued for hearing to September 27, 2018. On September 27, 2018, Petitioner appeared in person before the Arbitrator, along with counsel for both parties. At that hearing, Petitioner agreed to move forward with his case and begin testifying if his claims were reinstated. The Arbitrator granted the Petition to Reinstate, and trial commenced. Petitioner took the stand and began testifying. However, before Petitioner completed direct examination, the trial recessed and was continued, by agreement, to November 26, 2018.

On November 26, 2018, counsel for the parties appeared for the continued trial, Petitioner did not. No transcript of this proceeding was included in the record. The Arbitrator again continued the trial, to February 27, 2019. On February 27, 2019, counsel for both parties appeared before the Arbitrator, but Petitioner once again did not. A record was made at that proceeding, and Petitioner's counsel advised the Arbitrator that Petitioner had been informed of the February 27, 2019 trial date multiple times. The Arbitrator stated on the record that he had continued the

[1] The first two DWP's were of Petitioner's 11 WC 37232 claim only.

claims to February 27, 2019 as a final trial date. The Arbitrator noted that he had previously allowed the trial to be bifurcated as an accommodation to the parties, yet despite Petitioner's knowledge of the February 27, 2019 hearing, he did not appear. The Arbitrator advised counsel that he was dismissing Petitioner's claims for want of prosecution, and then entered a written order stating, "Cases were specially set for trial certain on 2-27-19 but Petitioner failed to appear for trial with no excuse or reason."

On March 26, 2019, Petitioner's counsel filed a timely Petition to Reinstate the claims, alleging that Petitioner's absence from trial on February 27, 2019 had been due to Petitioner not having being released by his treating psychiatrist, Dr. Pundy, to testify at trial. Counsel attached to his Petition a 3-month old note from Dr. Pundy dated November 27, 2018. That note stated Petitioner was under Dr. Pundy's care for major depression, PTSD and Panic Disorder, and that due to his Panic Disorder, Petitioner was not able to participate at a hearing at that time. Dr. Pundy's note also recommended that Petitioner receive 12 weekly therapy sessions, after which, Dr. Pundy hoped, Petitioner would be prepared to testify.

The hearing on Petitioner's Petition to Reinstate took place before the Arbitrator on June 20, 2019. Counsel for the parties appeared and a record was made. Petitioner's counsel informed the Arbitrator that Petitioner had not undergone any of the treatment which Dr. Pundy had recommended three months earlier. Petitioner's counsel admitted he did not have any notes from Dr. Pundy more recent than his November 27, 2018 note. Petitioner's counsel also informed the Arbitrator that Petitioner was not ready to proceed to trial because he had not obtained records from Coventry and Vocamotive. Finally, the Arbitrator was informed that Petitioner wanted to obtain a new attorney, and that he would not be ready to continue the trial for at least another three months.

The Arbitrator noted on the record that Petitioner presented no reason or excuse for failing to appear at the scheduled February 27, 2019 hearing. He noted that Petitioner's claims had been reinstated on three prior occasions, and that Petitioner had not appeared at any of the scheduled hearings since September 27, 2018. The Arbitrator stated he had seen essentially zero effort or evidence from Petitioner to show that he was serious about prosecuting and pursuing his rights under the Act. The Arbitrator found significant the fact that Petitioner had not produced to his own attorney any recent medical records to confirm his representations. At the conclusion of arguments on June 20, 2019, the Arbitrator denied Petitioner's Petition to Reinstate his claims. This Review followed.

Conclusions of Law:

It is a Petitioner's burden of proof to prove facts which justify reinstatement of a case after it has been dismissed. *Bromberg v. Industrial Comm'n,* 97 Ill. 2d 395 (1983). A Petitioner must exercise due diligence when pursuing a claim at the Workers' Compensation Commission. *Banks v. Indus. Comm'n,* 345 Ill. App. 3d 1138 (2004). Commission Rule 9020.90(c) states that in hearing Petitions to Reinstate, the Arbitrator shall apply standards of fairness and equity in ruling

on the Petition and consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions.

The facts establish that Petitioner's claims were dismissed and reinstated on three occasions over a three year period for various reasons. On the last occasion that Petitioner requested that his claims be reinstated, the Arbitrator noted that Petitioner presented no reason or excuse whatsoever for failing to appear at the scheduled February 27, 2019 hearing, despite being provided with several opportunities to appear for a trial previously since September 27, 2018. The Commission has reviewed the entire record and finds that the Petitioner has not proved facts which justify reinstatement of his claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 20, 2019 order denying Petitioner's Petition to Reinstate, in claim number 11 WC 37232, is affirmed.

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.

August 12, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-06-17-21
068

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC037546
Case Name	MCDONOUGH,PATRICK v. CITY OF CHICAGO
Consolidated Cases	11WC037232
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0411
Number of Pages of Decision	5
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Michael Greco
Respondent Attorney	Aukse Grigaliunas

DATE FILED: 8/12/2021

/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

Patrick McDonough,

Petitioner,

vs.

No. 13 WC 37546,
(Consolidated w/ 11 WC 37232)

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the record and reviewing the Arbitrator's June 20, 2019 order denying Petitioner's Petition to Reinstate claim number 13 WC 37546, hereby affirms the Arbitrator's order.

Findings of Fact:

On September 27, 2011, Petitioner filed an Application for Adjustment of Claim, 11 WC 37232, in which he alleged sustaining injuries to the man as a whole while working on July 30, 2011. On November 14, 2013, Petitioner filed his second Application for Adjustment of Claim, 13 WC 37546, in which he alleged sustaining injuries to his left leg, back, neck, and man as a whole while working on September 17, 2013. On April 8, 2016, an Order granting consolidation of the two claims was entered.

Petitioner's claims were given "final" trial dates by the Arbitrator on multiple occasions, and were dismissed when Petitioner failed to appear. Petitioner's claims have been dismissed for want of prosecution a total of four times, on: April 17, 2015, February 1, 2016, June 7, 2018, and

February 27, 2019.[1] The first three dismissals were vacated and Petitioner's claims were reinstated. This Review concerns Petitioner's fourth dismissal entered on February 27, 2019, and his subsequent Petition to Reinstate Case, which the Arbitrator denied on June 20, 2019.

Since 2016, both of Petitioner's claims have been on file for three or more years. The Arbitrator had set May 21, 2018 as one of several final trial dates. On May 21, 2018, counsel for both parties and the Petitioner appeared before the Arbitrator, but the trial did not proceed. Instead, the parties engaged in an hours-long pretrial conference with the Arbitrator, and all present agreed that the trial would begin on another specially set date of June 7, 2018. The Arbitrator also set a second agreed upon date of June 28, 2018, to, "ostensibly close proofs."

Petitioner did not appear on June 7, 2018. A record was made of that proceeding. The Arbitrator reported on the record that on May 21, 2018, Petitioner had made it clear that he wanted to proceed with his case, and that, "it was agreed by everyone that we would appear on today's date, June 7th, for a specially set trial where Petitioner would testify." The Arbitrator further noted that Petitioner "readily agreed to that."

Petitioner's reported reason for not appearing on June 7, 2018 was that he claimed to have obtained a note dated May 30, 2018 from his psychiatrist, Dr. Pundy, which indicated he was not psychologically able to testify. The Arbitrator stated that he had gone to great lengths to accommodate Petitioner. The Arbitrator noted that Petitioner waited almost one week after receiving Dr. Pundy's May 30, 2018 note before informing the Arbitrator and his attorney of it, or of his intention to not testify on June 7, 2018. The Arbitrator noted that Petitioner never requested a continuance of the June 7, 2018 hearing. The Arbitrator stated he did not place much weight upon Dr. Pundy's note, because no accompanying treating records or deposition testimony of that doctor were offered. The Arbitrator then entered an order dismissing Petitioner's claims for want of prosecution.

Petitioner filed a timely Petition to Reinstate his claims on July 17, 2018. That Petition was continued for hearing to September 27, 2018. On September 27, 2018, Petitioner appeared in person before the Arbitrator, along with counsel for both parties. At that hearing, Petitioner agreed to move forward with his case and begin testifying if his claims were reinstated. The Arbitrator granted the Petition to Reinstate, and trial commenced. Petitioner took the stand and began testifying. However, before Petitioner completed direct examination, the trial recessed and was continued, by agreement, to November 26, 2018.

On November 26, 2018, counsel for the parties appeared for the continued trial, Petitioner did not. No transcript of this proceeding was included in the record. The Arbitrator again continued the trial, to February 27, 2019. On February 27, 2019, counsel for both parties appeared before the Arbitrator, but Petitioner once again did not. A record was made at that proceeding, and Petitioner's counsel advised the Arbitrator that Petitioner had been informed of the February 27, 2019 trial date multiple times. The Arbitrator stated on the record that he had continued the

[1] The first two DWP's were of Petitioner's 11 WC 37232 claim only.

claims to February 27, 2019 as a final trial date. The Arbitrator noted that he had previously allowed the trial to be bifurcated as an accommodation to the parties, yet despite Petitioner's knowledge of the February 27, 2019 hearing, he did not appear. The Arbitrator advised counsel that he was dismissing Petitioner's claims for want of prosecution, and then entered a written order stating, "Cases were specially set for trial certain on 2-27-19 but Petitioner failed to appear for trial with no excuse or reason."

On March 26, 2019, Petitioner's counsel filed a timely Petition to Reinstate the claims, alleging that Petitioner's absence from trial on February 27, 2019 had been due to Petitioner not having being released by his treating psychiatrist, Dr. Pundy, to testify at trial. Counsel attached to his Petition a 3-month old note from Dr. Pundy dated November 27, 2018. That note stated Petitioner was under Dr. Pundy's care for major depression, PTSD and Panic Disorder, and that due to his Panic Disorder, Petitioner was not able to participate at a hearing at that time. Dr. Pundy's note also recommended that Petitioner receive 12 weekly therapy sessions, after which, Dr. Pundy hoped, Petitioner would be prepared to testify.

The hearing on Petitioner's Petition to Reinstate took place before the Arbitrator on June 20, 2019. Counsel for the parties appeared and a record was made. Petitioner's counsel informed the Arbitrator that Petitioner had not undergone any of the treatment which Dr. Pundy had recommended three months earlier. Petitioner's counsel admitted he did not have any notes from Dr. Pundy more recent than his November 27, 2018 note. Petitioner's counsel also informed the Arbitrator that Petitioner was not ready to proceed to trial because he had not obtained records from Coventry and Vocamotive. Finally, the Arbitrator was informed that Petitioner wanted to obtain a new attorney, and that he would not be ready to continue the trial for at least another three months.

The Arbitrator noted on the record that Petitioner presented no reason or excuse for failing to appear at the scheduled February 27, 2019 hearing. He noted that Petitioner's claims had been reinstated on three prior occasions, and that Petitioner had not appeared at any of the scheduled hearings since September 27, 2018. The Arbitrator stated he had seen essentially zero effort or evidence from Petitioner to show that he was serious about prosecuting and pursuing his rights under the Act. The Arbitrator found significant the fact that Petitioner had not produced to his own attorney any recent medical records to confirm his representations. At the conclusion of arguments on June 20, 2019, the Arbitrator denied Petitioner's Petition to Reinstate his claims. This Review followed.

Conclusions of Law:

It is a Petitioner's burden of proof to prove facts which justify reinstatement of a case after it has been dismissed. *Bromberg v. Industrial Comm'n,* 97 Ill. 2d 395 (1983). A Petitioner must exercise due diligence when pursuing a claim at the Workers' Compensation Commission. *Banks v. Indus. Comm'n,* 345 Ill. App. 3d 1138 (2004). Commission Rule 9020.90(c) states that in hearing Petitions to Reinstate, the Arbitrator shall apply standards of fairness and equity in ruling

on the Petition and consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions.

The facts establish that Petitioner's claims were dismissed and reinstated on three occasions over a three year period for various reasons. On the last occasion that Petitioner requested that his claims be reinstated, the Arbitrator noted that Petitioner presented no reason or excuse whatsoever for failing to appear at the scheduled February 27, 2019 hearing, despite being provided with several opportunities to appear for a trial previously since September 27, 2018. The Commission has reviewed the entire record and finds that the Petitioner has not proved facts which justify reinstatement of his claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 20, 2019 order denying Petitioner's Petition to Reinstate, in claim number 13 WC 37546, is affirmed.

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.

August 12, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-06-17-21
068

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC002165
Case Name	OLLER, CLINTON v. ILLINOIS DEPARTMENT OF TRANSPORTATION (IDOT)
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) and 8a
Decision Type	Commission Decision
Commission Decision Number	21IWCC0412
Number of Pages of Decision	17
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Mary Massa
Respondent Attorney	Cori Stewart

DATE FILED: 8/12/2021

/s/Kathryn Doerries, 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify TTD period reduced	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CLINTON OLLER,

Petitioner,

vs. NO: 19 WC 02165

ILLINOIS DEPARTMENT OF TRANSPORTATION (IDOT),

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, affirms the period of temporary total disability from 9/24/18 through 10/22/18 (4-1/7 weeks) as awarded. The Commission, however, modifies the second period of TTD awarded, 1/3/19 through 9/10/20. The Commission notes that Dr. Robson released Petitioner to return to work without restrictions on 1/3/19 (PX4). Dr. Robson testified he restricted Petitioner from returning to work starting on 2/6/19. (PX14, T.13) Thus, the Commission finds Petitioner was temporarily and totally disabled from 2/6/19 through 9/10/20, and awards TTD benefits for this period.

All else otherwise is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $868.13 per week for a period of 87-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,764.52 for medical expenses under §8(a) of the Act. Respondent shall pay for prospective medical care consisting of cervical discectomy and fusion surgery recommended by Dr. Robson, as provided in §8(a) and §8.2 of the Act and subject to the medical fee schedule.

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

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

August 12, 2021

o- 8/10 /21
KAD/jsf

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0412
NOTICE OF 19(b) ARBITRATOR DECISION

OLLER, CLINTON Case# **19WC002165**
Employee/Petitioner

IL DEPT OF TRANSPORTATION
Employer/Respondent

On 10/19/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1580 BECKER SCHROADER & CHAPMAN
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

6147 ASSISTANT ATTORNEY GENERAL
CORI STEWART
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

1430 BUREAU OF RISK MANAGEMENT
801 S 7TH ST
6TH FL
SPRINGFIELD, IL 62794

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

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

OCT 19 2020

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CLINTON OLLER
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # **19** WC **002165**

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 **Herrin**, on **September 10, 2020.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**67,716.45**; the average weekly wage was $**1,302.23**.

On the date of accident, Petitioner was **51** years of age, **married** with **2** children under 18.

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

Respondent shall be given a credit of $**69.952.16** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**69,952.16**.

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

ORDER

Petitioner proved by the preponderance of the evidence that his current cervical condition is causally related to his September 19, 2018 accident. The Arbitrator finds that Petitioner also sustained a left shoulder contusion as a result of his September 19, 2018 accident which resolved prior to the hearing, as set forth in the Conclusions of Law attached hereto,

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $135.00 to Family & Internal Medicine/HSHS Medical Group, $308.58 to Mid America Radiology, and $2,320.94 to Elite Imaging, as provided in Sections 8(a) and 8.2 of the Act, as set forth in the Conclusions of Law attached hereto,

Respondent shall pay for prospective medical care consisting of the cervical discectomy and fusion surgery recommended by Dr. Robson, as set forth in the Conclusions of Law attached hereto,

Petitioner is entitled to temporary total disability benefits of $868.13/week for 92 weeks, from September 24, 2018 thru October 22, 2018 and from January 3, 2019 thru September 10, 2020, pursuant to Section 8(b) of the Act, less a credit of $69,952.16 for temporary total disability benefits Respondent previously paid, as set forth in the Conclusions of Law attached hereto, .

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

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

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

Signature of Arbitrator

10/15/2020
Date

OCT 19 2020

Procedural History

This matter proceeded to trial pursuant to Sections 19(b) and 8(a) of the Act on September 10, 2010. The issues in dispute are whether Petitioner sustained accidental injuries that arouse out of and in the course of employment, whether Petitioner's current condition is causally connected to his injury, whether Respondent is liable for unpaid medical bills and whether Respondent is liable for TTD benefits and prospective medical care.

Findings of Fact

On September 19, 2018, Clinton Oller (hereinafter referred to as "Petitioner") testified he was employed with the Illinois Department of Transportation (Hereinafter referred to as "Respondent") as a highway maintainer on the Highland Bridge Crew. As a highway maintainer, his was responsible for maintaining 1,100 bridges in District 8 and his duties including breaking concrete, jack hammering, shoveling concrete, troweling concrete, tying rebar, repairing bearings, cleaning off bridge decks, repairing beams, welding, drilling, and traffic control.

Petitioner testified, on September 19, 2018, he was performing a roaming operation picking up a speed drop signs and sandbags on I-255. Petitioner picked up a 55-pound rack and placed it on his right shoulder. The rack was made of steel and weighed 55 pounds. While carrying the steel rack on his right shoulder, Petitioner was also picking up sandbags with his left arm. Petitioner testified while attempting to cross the highway he stumbled and fell landing on his left shoulder. (T. 10-11).

Petitioner testified one of his co-workers slowed traffic down while another co-worker picked the rack off Petitioner and helped him off the highway. Petitioner testified his left shoulder and arm were sore, but he did not immediately seek medical care until he started to experience numbness and tingling. At that time, he sought medical care from his family doctor.

On September 22, 2018, Petitioner was seen at HSHS Southern Illinois Division St. Joseph Hospital Urgent Care. At that time, he reported feeling dizzy after falling while walking with his hands full. Petitioner stated he was carrying something that may have struck his head. Petitioner complained of left shoulder pain that went into his left neck. The exam of the left shoulder showed full range of motion with pain. The exam also showed spasms and pain at the posterior trapezoid to the left neck. A CT of the scan of the brain was performed which showed no evidence of intracranial hemorrhaging. Petitioner was diagnosed with a left shoulder strain and closed head injury. Petitioner was prescribed Ibuprofen and Tizanidine. (PX 1).

On September 24, 2018, Petitioner was seen by Jacqueline Bode, APN, at Family and Internal Medicine in Highland, Illinois. At that visit, Petitioner reported while at work he was carrying a rack on one side and a sandbag on the other when he tripped and fell onto his left shoulder. Petitioner said that he

took two sick days off work. Petitioner reported feeling dizzy and his left shoulder was sore, and he was experiencing numbness and tingling down to his elbow. Petitioner described the pain radiated to the left upper arm and the symptoms resulted from his fall at work. The examination noted left shoulder and tenderness at C2 and pain with forward flexion and abduction. Petitioner's range of motion was found to be abnormal. Petitioner was assessed with left shoulder strain and concussion without loss of consciousness. X-rays were ordered and Petitioner was taken off work. (PX 2).

Petitioner returned to Family and Internal Medicine on September 28, 2018. At that visit, Petitioner reported left shoulder pain and pain when raising his left arm above his head or when he puts his arm behind his back. The medical records noted that Petitioner's pain was worse with shoulder motion, external rotation and lifting. The examination showed decreased range of motion and weakness in the left harm. Physical therapy was recommended. (PX 2).

Petitioner followed up at Family and Internal medicine on October 5, 2018. At that time, Petitioner reported numbness and tingling in his left hand and fingers. The exam showed pain with palpation to the left shoulder, left upper back to the supraspinatus muscle. Petitioner was assessed with a left shoulder injury and his physical therapy was increased to 4-5 sessions. Petitioner was issued work restrictions of no heavy lifting with left arm. (PX 2).

On October 12, 2018, Petitioner returned to Internal Medicine reporting pain to the left anterior shoulder that shoots down his arm and makes his left hand go numb and burn. Petitioner also reported pain with external rotation. The exam showed left shoulder tenderness and abnormal range of motion. Petitioner was assessed with left shoulder pain and he was prescribed Prednisone and referred to Dr. Dennis Dusek for an orthopedic evaluation. Petitioner was taken off work at that time. (PX 2).

Petitioner presented to Dr. Dusek of Signature Orthopedics on October 22, 2018. At that visit, Petitioner reported left neck pain going down his left scapula with shooting pain down his left arm. Petitioner reported a history of working for Respondent for 17 years as a highway maintainer and he was picking up road signs running across the lands of traffic carrying a rack and holding sandbags when he fell. The exam the left shoulder showed instability, full shoulder range of motion, negative impingement signs, no tenderness over the AC joint and excellent strength of internal and external rotation. The exam of the cervical spine showed pain with motion and rotation of only 60 degrees to both the right and left. Dr. Dusek noted that Petitioner lacks one fingerbreadth of touching chin to chest. X-rays of the left shoulder showed chronic calcific thin deposit in front to the upper subscapularis tendon at the region of the lower rotator interval. Dr. Dusek opined that his issue was incidental and not part of Petitioner's current problem. X-rays of the cervical spine showed good lordosis and disc space until the C6-7 level. The x-rays also showed bone spur impingement on the left C6-7 neural foraminal. Dr.

Dusek assessed acute cervical myofascial strain. Dr. Dusek opined that Petitioner had a preexisting cervical spine problem which he was asymptomatic until he fell and aggravated his cervical spondylosis. Dr. Dusuk recommended cervical traction and prescribed Mobic. Dr. Dusek scheduled a follow up appointment in a month and released Petitioner to return to work full duty. (PX 3).

On November 20, 2018, Petitioner returned to Dr. Dusek reporting his neck pain down his left arm and experiencing tingling. Dr. Dusek noted the pain goes up and down his arm and the pain is occasioned by neck motion and not shoulder movement. Dr. Dusek also noted Petitioner had a prior table saw injury to his hand, but his current symptoms involve the arm and supersedes the original area of numbness from the old table say injury. Dr. Dusek assessed acute cervical myofascial strain and he referred Petitioner to a neck specialist. (PX 3).

On December 27, 2018, Petitioner presented to Dr. David Robson of Advanced Spine Institute. At that time, Petitioner reported while caring traffic controls signs across the highway he fell onto his left shoulder. Petitioner further reported left shoulder and neck pain, numbness and tingling. The exam noted tenderness to palpation of the shoulder and trapezius region. The cervical range of motion was 10 degrees of extension, 80 degrees of flexion, 80 degrees of rotation to the right and left. Dr. Robson assessed likely cervical radiculopathy and prescribed a cervical MRI. Dr. Robson opined Petitioner's September 19, 2018 accident caused him to become symptomatic and that Petitioner is not at maximum medical improvement. Dr. Robson indicated that he agreed with Dr. Dusek that the shoulder was relatively normal and further workup was required for the cervical spine. (PX 4).

On January 15, 2019, Petitioner underwent an MRI at Elite Imaging. The MRI impression consisted of multilevel disease with disc protrusions more prominent at C6-7 bilaterally and more prominent on the left at C4-5 but also with smaller protrusions at C3-4 and C5-6. The MRI findings at C6-7 indicate a broad-based protrusion across the midline creating flattening of the dura and diminished CSF around the cord but no significant central stenosis. There were protrusions extending toward both foraminal. (PX 11).

On February 6, 2019, Petitioner returned to Dr. Robson reporting neck and left shoulder pain with tingling through the left arm. The exam noted tenderness to palpation of the shoulder and trapezius region. The cervical range of motion was 10 degrees of extension, 80 degrees of flexion, 80 degrees of rotation to the right and left. Dr. Robson indicated the MRI shows a C4-5 disc protrusion and a bilateral left greater than right C6-7 protrusion which, he opined, was the more dominate lesion producing Petitioner's current symptoms. Dr. Robson diagnosed a cervical herniated nucleus pulposus and he prescribed a left C6-7 interlaminar epidural steroid injection. Dr. Robson took Petitioner off work. (PX 4).

On April 3, 2019, Petitioner contacted Advanced Spine Institute reporting he was not able to lift his left arm over his shoulder. Petitioner said he was going to urgent care to have it checked out. (PX 4). Later that

day, Petitioner presented to urgent care reporting he woke up with a lot of main with shoulder movement. The exam showed limited range of motion and Petitioner was unable to lift his hand over his head. Tenderness was noted around the anterior rotator cuff. X-rays of the left shoulder were taken which showed degenerative changes at the acromioclavicular joint and a 14 mm and 11 mm calcification projecting anterior to the left humeral head. Petitioner was released and instructed to ice his shoulder. (PX 1).

On April 11, 2019, Petitioner underwent the Left C6-7 paramedian epidural steroid injection with Dr. Patricia Hurford of The St. Louis Spine and Orthopedic Surgery Center. (PX 12). On April 24, 2019, Petitioner returned to Dr. Robson reporting complete relief of his pain. Petitioner further reported after the injection his pain level reduced to a level of 2. The exam showed tenderness to palpation of the shoulder and trapezius region. Petitioner's cervical range of motion was 10 degrees of extension, 80 degrees of flexion and 80 degrees of rotation. Dr. Robson diagnosed a left C6-7 disc herniation with improvement from the epidural steroid injection. Dr. Robson opined that Petitioner's locked left shoulder involves loose bodies in the shoulder joint which is unrelated to Petitioner's work accident. Dr. Robson recommended repeating the left C6-7 interlaminar epidural steroid injection and he kept Petitioner off work. (PX 4).

On July 1, 2019 Petitioner was examined by Dr. James Emanual pursuant to Section 12 of the Act. Dr. Emanuel testified that 90% of his practice involves treating shoulders and 10% of his practice involves performing IME's. Dr. Emanual testified the majority of Petitioner's complaints were from the neck, the base, radiating into the left trapezius group. The examination of the left shoulder showed full range of motion with no atrophy. Dr. Emanual noted that Petitioner experienced pain with extremes of motions and the Spurling's test caused pain at the base of Petitioner's neck that radiated into the left trapezoid muscle group and appeared to also go into the left shoulder. Dr. Emanual reviewed the x-rays an MRI and opined they showed some degenerative disc disease at C6-7 with evidence of a bulging disc with protrusions bilaterally but more prominent on the left especially at C4-5 with also some bulges at C3-4 and C5-6. Dr. Emanual diagnosed radiculopathy emanating from the central spine. Regarding the left shoulder, Dr. Emanual opined Petitioner sustained a contusion to the left shoulder that may have aggravated some arthritic changes in the acromioclavicular joint, but he is now at maximum medical improvement and could work without restrictions for the left shoulder. Dr. Emanual testified that he would defer to a neck specialist regarding Petitioner's cervical condition. (RX 2).

On September 5, 2019, Petitioner underwent a second left C6-7 epidural steroid injection with Dr. Hurford. (PX 12). On September 18, 2019, Petitioner returned to Dr. Robson reporting less pain relief from the second injection. Dr. Robson diagnosed a herniated disc at C6-7 with continued pain after physical therapy and two injections. At that time, Dr. Robson recommended an anterior cervical discectomy with partial vertebrectomy and fusion at C6-7. Dr. Robson kept Petitioner off work until after the surgery. (PX 4).

On December 4, 2019, Petitioner was examined by Dr. Michael Chabot pursuant to Section 12 of the Act. Dr. Chabot diagnosed Petitioner with a contusion injury to the left shoulder, with strain injuries to the neck and left shoulder associated with his work injury of September 18, 2018. He stated that there was no objective findings of neurologic changes or neural deficits that would define the C6-7 level as the source of his complaints and no evidence of neurologic changes involving the upper extremities. Dr. Chabot testified he felt Petitioner's treatment was reasonable and necessary regarding both injections. Dr. Chabot opined that he does not agree that Petitioner needs surgery because he is not using pain medications for his symptoms and he found no neurologic changes involving the upper extremities to suggest active radiculopathy. Dr. Chabot opined that Petitioner was at maximum medical improvement and he could return to work full duty. (RX 1).

Dr. Robson testified that the MRI showed a disc protrusion at C6-7, smaller on the right, and at his lowest cervical motion segment Petitioner had a herniated disc. Dr. Robson testified Petitioner's complaints originate from the C7 nerve root. Dr. Robson testified Petitioner has a herniated disc that is symptomatic at the C6-7 level on the left. Dr. Robson noted Petitioner's pain complaints went away, for a short period of time, after the steroid injections. Dr. Robson testified he recommended surgery because Petitioner became symptomatic after his accident, has symptoms consistent with a herniated disc at C6-7 and failed conservative treatment. Dr. Robson opined that Petitioner's September 19, 2018 injury caused the herniated disc. Dr. Robson testified Petitioner was asymptomatic prior to his injury and became symptomatic after his injury. Dr. Robson also opined the surgery is related to Petitioner's work accident and as of February of 2018, he took Petitioner off work. (PX 4).

Petitioner testified that prior to his work accident he had no problems with his left shoulder or back. Petitioner testified he is in constant pain. The pain is in his neck and runs down his spine into his left shoulder. Petitioner testified there are times his neck locks up and he can't turn his head. Petitioner testified he would like to have the surgery because he wants to get back to work.

The Arbitrator found the Petitioner's testimony to be credible.

Conclusions of Law

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

With respect to issue "C" whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

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

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

The Arbitrator finds that Petitioner proved by the preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment. Petitioner testified he was injured at work on September 19, 2018 when he fell while running across the highway caring a steel rack and sandbags. The Arbitrator finds Petitioner reported similar histories to various medical providers. The Arbitrator notes that Respondent failed to proffer any testimony conflicting with Petitioner's testimony.

With respect to issue "F", whether Petitioner's current condition of ill-being is causally 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). When a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Shafer v. Illinois Worker's Compensation Comm'n,* 2011 IL App. (4th) 100505 WC. The chain-of-events principles have been applied where an accident is claimed to have aggravated a preexisting condition. See *Schroeder v. Illinois Worker's compensation Comm'n,* 2017 IL App. (4th) 160192 WC.

The Arbitrator has carefully reviewed and considered all the evidence and finds that Petitioner has proven by the preponderance of the credible evidence that his current cervical spine condition is causally related to his work accident of September 10, 2020, as set forth more fully below. The Arbitrator also finds that Petitioner sustained a sprain to his left shoulder which resolved prior to the hearing.

Petitioner testified that prior to September 19, 2018 he was not experiencing any neck and left shoulder problems and he was able to perform his job duties. After his work accident of September 19, 2018 Petitioner worked light duty attempted to return to work full duty before being taken off all work by Dr. Robson. The Arbitrator finds the opinions of Dr. Robson more persuasive than the opinions of Dr. Chabot. Dr. Robson opined Petitioner was asymptomatic prior to his September 19, 2018 work accident but became symptomatic after the accident. Dr. Robson opined the work accident caused a disc herniation at C6-7. The Arbitrator notes the medical records reflect Petitioner received relief after undergoing the epidural injections at the C6-7 level which support Dr. Robson's opinion.

The Arbitrator also finds that Dr. Robson's opinions are consistent with the opinions of Dr. Emanuel, who performed the Section 12 examination for Petitioner's shoulder, and Dr. Dusek. Dr. Emanual testified the majority of Petitioner's symptoms were from the base of the neck radiating into the left trapezius group. Dr. Emanual examined Petitioner and noted pain with extremes of motion and the Spurling's test caused pain in the base of the neck radiating into the left trapezoid muscle group and left shoulder. Dr. Emanual opined Petitioner's work accident caused a whiplash type injury to the cervical spine which substantially aggravated some preexisting degenerate disc disease in the cervical spine causing irritation of the exiting nerve roots on the left side. (RX 2, pg. 14). Dr. Dusek opined that Petitioner had a preexisting cervical spine problem which he was asymptomatic until he fell and aggravated his cervical spondylosis. (PX 3). Regarding the left shoulder, Dr. Emanual opined Petitioner sustained a contusion to the shoulder which may had aggravated some arthritic change in the acromioclavicular joint which resolved. Dr. Emanual also opined Petitioner was at maximum medical improvement and had no restrictions with regards to the left shoulder. (RX 2.pg. 12-13).

Dr. Chabot testified Petitioner had a chronic degenerative cervical condition and he sustained a neck strain as a result of the work accident. Dr. Chabot opined Petitioner was at maximum medical improvement and could return to work full duty. (RX 1, pg. 15). Dr. Chabot testified his exam failed to show evidence of neurologic changes or functional deficits that would have precluded Petitioner from returning to work. (RX 1, pg. 14). The Arbitrator finds that Dr. Chabot failed to sufficiently address the issue of whether Petitioner's work-related accident aggravated, contributed or accelerate his preexisting arthritic condition.

With respect to issue "J" whether the medical services provided were reasonable and necessary, the Arbitrator finds as follows:

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

Petitioner seeks payment for medical treatment provided by Family & Medicine/HSHS Medical Group, in the amount of $135.00, Mid America Radiology, in the amount of $308.58, and from Elite Imaging, in the amount of $2,320.94. The Arbitrator finds that Petitioner has proved by the preponderance of the evidence that the medical treatment was causally related to his accident and necessary to diagnose, relieve or cure Petitioner from the effects of his injury. The Arbitrator notes Respondent failed to proffer any opinions the medical treatment was not reasonable or necessary. As such, Respondent shall pay Petitioner the amounts due from Family & Medicine/HSHS Medical Group, Mid American Radiology and Elite Imaging, as outlined in PX 15, as provided in Sections 8(a) and 8.2 of the Act.

With respect to issues "K" whether Petitioner is entitled to prospective medical care, the Arbitrator finds as follows:

The Arbitrator finds Petitioner proved by the preponderance of the evidence that he is entitled to prospective medical care consisting of the cervical discectomy and fusion surgery recommended by Dr. Robson. As stated above, the Arbitrator found the opinions of Dr. Robson more persuasive than the opinions of Dr. Chabot. Dr. Robson opined surgery was recommended because Petitioner had an accident, became symptomatic consistent with a herniated disc at C6-7, and did not improve with therapy, injections and other conservative treatment. (PX 14, pg. 10). Dr. Robson testified Petitioner has a herniated disc which is symptomatic at the C6-7 level on the left. Dr. Robson also testified Petitioner's complaints were easily explained by the C7 nerve root as that travels through that region. Dr. Robson further testified the relief Petitioner received after the injections shows that his diagnosis is likely correct.

Dr. Chabot opined that surgery was not necessary because Petitioner was not taking pain medication, showed no neurologic changes showing active radiculopathy and the lack of objective physical findings. (RX 1,

pg. 14). Dr. Chabot testified he did not ask Petitioner why he did not take pain medication. Regarding this issue, Dr. Chabot testified that "*...if they don't take it, it's because they don't need it, but I didn't ask him specifically why he wasn't taking it...*". (RX 1, pg. 17). The Arbitrator finds that Dr. Chabot's opinion regarding surgery was based, in part, upon why Petitioner was not taking pain medication. Dr. Chabot surmises the reason why Petitioner did not take pain medicine was because he was not in pain. The Petitioner testified that he continues to experience pain. The Arbitrator finds that Dr. Chabot's opinion was based, in part, upon the surmise or conjecture. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507 (First Dist. 2000). The Arbitrator notes Drs. Robson and Emanuel found objective physical findings and neurologic changes. The Arbitrator also notes that Dr. Chabot's exam found restrictions on range of motion.

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

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). For an employee to be entitled to total disability benefits under the act he must prove he is "totally incapacitated from work by reason of the illness attending the injury." *Mt. Olive Coal Co. v. Industrial Comm'n*, 129 N.E. 103, 104 (Ill. 1920).

Petitioner seeks TTD from September 24, 2018 thru October 22, 2018 and from January 3, 2019 thru September 10, 2020, representing 92 weeks. Respondent paid TTD benefits totaling $69,952.16. (Arb. Ex. #1). The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that he has not worked but was unable to work due to his injury. As stated above, the Arbitrator found that Petitioner's current cervical condition is causally related to his work accident. The Arbitrator also finds the opinion of Dr. Robson persuasive that Petitioner is not at maximum medical improvement. As such, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits of $868.13/week for 92 weeks, from September 24, 2018 thru October 22, 2018 and from January 3, 2019 thru September 10, 2020, pursuant to Section 8(b) of the Act, less a credit of $69,952.16 for temporary total disability benefits Respondent previously paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC032462
Case Name	HUBERT,LYNN v. CHESTER MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0413
Number of Pages of Decision	13
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jason Coffey
Respondent Attorney	Aaron Wright

DATE FILED: 8/13/2021

/s/Marc Parker, 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

Lynn Hubert,

Petitioner,

vs. NO: 17 WC 32462

Chester Mental Health Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, causal connection, notice 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 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.

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.

August 13, 2021

MP:yl
o 8/5/21
68

/s/ *Marc Parker*
Marc Parker

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0413

HUBERT, LYNN
Employee/Petitioner

Case# **17WC032462**

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

On 11/17/2020, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERHOVER & COFFEY ET AL
JASON COFFEY
600 STATE ST
CHESTER, IL 62233

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

0558 ASSISTANT ATTORNEY GENERAL
AARON WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

NOV 17 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lynn Hubert
Employee/Petitioner

v.

Chester Mental Health Center
Employer/Respondent

Case # 17 WC 32462

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 Herrin, on October 16, 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 August 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 $118,800.00; the average weekly wage was $2,284.62.

On the date of accident, Petitioner was 61 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has 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 amounts paid under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,440.60 per week for five-sevenths of a week, commencing October 20, 2017, through October 27, 2017, (one and one-sevenths weeks less three-sevenths weeks waiting period) as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $790.64 per week for 19 weeks because the injury sustained caused the 10% 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 13, 2020
Date

NOV 17 2020

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent. The Application alleged a date of accident (manifestation) of August 22, 2017, and that Petitioner sustained repetitive trauma to her "Right hand/wrist" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident, notice and causal relationship. Petitioner claimed she was entitled to temporary total disability benefits for one and one-sevenths weeks, commencing October 20, 2017, through October 27, 2017. Respondent agreed Petitioner was temporarily totally disabled for the aforestated period of time, but disputed its liability for same (Arbitrator's Exhibit 1).

Petitioner worked for Respondent for approximately 27 years and retired in late 2017. Petitioner was hired in 1988 and worked as a clerk/typist. Petitioner took a leave of absence from 1991 to 1993 and obtained a Master's Degree. Petitioner returned to her employment with Respondent in January, 1994, and worked as a social worker. Petitioner subsequently became a Unit Director and, in the last three years of her employment by Respondent, Petitioner was the Assistant Business Manager.

Petitioner testified that all of the positions she held while employed by Respondent required her to perform clerical work approximately five to seven hours per day. This included typing, filing and handwriting. Petitioner would prepare various reports, progress notes, evaluations of fellow employees, etc. Petitioner was right hand dominant and performed a significant amount of the preceding activities with her right hand.

Over a period of years, Petitioner began to experience right hand symptoms, in particular, that her right hand would go to sleep. Petitioner testified that in the last two years of her employment by Respondent, it got progressively worse.

Petitioner was seen by Dr. Mark Pruess, her family physician, on July 6, 2009, for a number of health issues including right hand symptoms. Dr. Pruess opined Petitioner had probable right hand carpal tunnel syndrome. However, there was no reference to Petitioner's work activities and Petitioner did not follow up with any further evaluation or diagnostic tests until 2017 (Respondent's Exhibit 4).

On August 22, 2017 (the date of manifestation alleged in the Application), Petitioner underwent EMG/nerve conduction studies. They were positive for right hand carpal tunnel syndrome (Referenced in Petitioner's Exhibit 3).

On August 28, 2017, Petitioner completed and signed an Employee's Notice of Injury wherein Petitioner indicated she had sustained a repetitive work injury to her right hand/wrist. On September 1, 2017, a First Report of Injury was completed by Sheri Bliss on behalf of the Respondent. Both documents were received into evidence at trial (Petitioner's Exhibit 6).

Petitioner was subsequently treated by Dr. Harvey Mirly, an orthopedic surgeon. Dr. Mirly first saw Petitioner on September 26, 2017. At that time, Petitioner informed Dr. Mirly she had

pain/numbness in her right hand for the past year which had worsened in the preceding six months. Petitioner advised Dr. Mirly that she had worked for Respondent in clerical positions for 27 years. Dr. Mirly noted Petitioner had the non-occupational risk factor of being female, but no history of thyroid problems, riding motorcycles, diabetes and Petitioner was a non-smoker. Dr. Mirly reviewed the EMG/nerve conduction studies performed on August 22, 2017, and opined Petitioner had right carpal tunnel syndrome. He recommended Petitioner undergo carpal tunnel release surgery (Respondent's Exhibit 3).

On October 20, 2017, Dr. Mirly performed surgery on Petitioner's right wrist/hand. The procedure consisted of an open carpal tunnel release (Petitioner's Exhibit 2).

At the request of Petitioner's counsel, Dr. Mirly prepared a report dated October 20, 2017, wherein he opined as to whether Petitioner's right hand condition was caused or aggravated by her work activities. Dr. Mirly noted there were several high quality studies which had revealed an association between carpal tunnel syndrome and computer work. Dr. Mirly specifically noted Petitioner's long work history of 27 years and, while he noted the diagnosis of carpal tunnel syndrome was multifactorial, he opined her work activities would have been a contributing factor (Respondent's Exhibit 3).

Dr. Mirly saw Petitioner on October 26, 2017, removed the sutures and applied a splint. At that time, he released Petitioner from care (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Mirly was deposed on September 28, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Mirly's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, Dr. Mirly testified Petitioner informed him of her work duties. He also discussed non-occupational factors for carpal tunnel syndrome, including Petitioner being female, but there was no history of thyroid problems, no motorcycle riding and no smoking (Petitioner's Exhibit 4; pp 7-9).

In regard to causality, Dr. Mirly testified there was a causal relationship between Petitioner's right carpal tunnel syndrome condition and her job duties. Dr. Mirly did testify the job duties were a contributing factor, but not solely causative. He referenced an article entitled "Clinical Practice Guidelines of Carpal Tunnel Syndrome" and noted it determined there was a higher risk of individuals who had performed computer work in excess of eight years of developing carpal tunnel syndrome. Dr. Mirly noted Petitioner had worked in such capacity for 27 years (Petitioner's Exhibit 4; pp 17-18).

On cross-examination, Dr. Mirly admitted he did not know how many hours Petitioner spent on a keyboard on a daily basis; however, he again noted the fact Petitioner had worked for 27 years doing computer work and handwriting. He also agreed Petitioner being female and 61 years of age were also risk factors (Petitioner's Exhibit 4; pp 25-27).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on February 5, 2019. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records and information regarding Petitioner's job which were provided to him by Respondent. Dr. Sudekum opined Petitioner had probable prior right carpal tunnel syndrome,

now resolved because of her undergoing surgery. In regard to causality, Dr. Sudekum attributed Petitioner's right carpal tunnel syndrome to non-occupational risk factors which he opined were Petitioner being female, 62 years of age, osteoarthritis of the upper extremities, hyperlipidemia, peripheral vascular disease and a history of a prior right ruptured biceps tendon. He also referenced peer reviewed studies which found no relationship between keyboarding and the development of carpal tunnel syndrome (Respondent's Exhibit 2).

At trial, Petitioner testified her right hand lacks the strength it had previously. Petitioner also stated she experiences difficulties especially when opening jars. As aforestated, Petitioner retired in late 2017.

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 August 22, 2017, and Petitioner's current condition of ill-being in regard to her right hand is causally related to her work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the repetitive use of her right hand for a period of 27 years was unrebutted.

While Petitioner was previously diagnosed with probable right carpal tunnel syndrome in July, 2009, Petitioner did not follow up with any further treatment or diagnostic tests until 2017.

Petitioner underwent EMG/nerve conduction studies on August 22, 2017 (the date of manifestation) which were positive for right carpal tunnel syndrome.

Petitioner's treating physician, Dr. Mirly, opined that Petitioner's work activities over a period of 27 years were a contributing factor to the development of her right carpal tunnel syndrome. He did acknowledge Petitioner had other risk factors of being female and 62 years of age.

Respondent's Section 12 examiner, Dr. Sudekum, opined Petitioner's right carpal tunnel syndrome was attributable to several risk factors which were Petitioner being 62 years of age, female, osteoarthritis of the upper extremity, hyperlipidemia, peripheral vascular disease and a history of a prior right ruptured biceps tendon.

The Arbitrator finds the opinion of Dr. Mirly to be more persuasive than that of Dr. Sudekum in regard to causality.

In regard to disputed issue (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes the following:

As noted herein, Petitioner's injury manifested itself on August 22, 2017. Petitioner prepared and signed an Employee's Notice of Injury on August 28, 2017, which was within the time required by the Act.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of five-sevenths of a week, commencing October 20, 2017, through October 27, 2017 (one and one-sevenths weeks less three-sevenths weeks waiting period) as provided in Section 8(b) of the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner and Respondent stipulated Petitioner was disabled for the aforestated period of time.

In regard to disputed issue (L) the Arbitrator concludes Petitioner had sustained permanent partial disability to the extent of 10% loss of use of the right hand.

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 in a variety of positions, all of which required repetitive use of her right hand. Petitioner retired shortly after undergoing surgery. The Arbitrator gives this factor minimal weight.

Petitioner was 61 years of age at the time she sustained the injury and 64 years of age at the time of trial. There was no evidence Petitioner retired because of the right hand injury, but she will have to live with the effects of the injury for the remainder of her natural life. The Arbitrator gives this factor minimal weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained a right hand injury which caused carpal tunnel syndrome ultimately requiring surgery. Petitioner continues to experience a lack of strength and difficulty opening jars. The Arbitrator finds the preceding complaints to be consistent with the injury Petitioner sustained. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC036050
Case Name	KARHLIKER,THOMAS R v. STATE OF ILLINOIS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0414
Number of Pages of Decision	15
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Timothy Shay
Respondent Attorney	Chelsea Grubb

DATE FILED: 8/13/2021

/s/Christopher Harris, 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

THOMAS KARHLIKER,

Petitioner,

vs. NO: 18 WC 36050

STATE OF ILLINOIS/HOUSE OF REPRESENTATIVES,

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, medical expenses, and permanent partial disability (PPD) benefits, 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 13, 2020 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

August 13, 2021

CAH/pm
D: 8/5/2021
052

Christopher A. Harris
Christopher A. Harris

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0414

KARHLIKER, THOMAS
Employee/Petitioner

Case# **18WC036050**

ST OF IL/HOUSE OF REPRESENTATIVES
Employer/Respondent

On 10/13/2020, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

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

4993 ASSISTANT ATTORNEY GENERAL
CHELSA GRUBB
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

OCT 13 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Thomas Karhliker
Employee/Petitioner

v.

State of Illinois/House of Representatives
Employer/Respondent

Case # 18 WC 36050

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **08/26/20**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 11, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$6,250.00**; the average weekly wage was **$120.19**.

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 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**. All TTD paid.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 10, directly to the providers, according to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent is ordered to pay Petitioner $120.19 per week for a period of 78 and 1/7 weeks, representing temporary total disability benefits from January 12, 2017 through July 13, 2018.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $120.19/week for 141.2 weeks, because the injuries sustained to Petitioner's left elbow and left hand caused a 40% loss of use of the left arm and a 20% loss of use of the left hand.

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

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

Signature of Arbitrator

10/11/20
Date

ICArbDec p. 2

OCT 13 2020

FINDINGS OF FACT

Petitioner is 67 years old and graduated from Auburn High School in 1971. TR, p. 7. After graduating from high school, he earned an Associate's Degree from Lincoln Land Community College and a Bachelor's Degree from the University of Illinois-Springfield. TR, p. 8. He has also earned a degree in police administration from the University of Louisville. TR, p. 8.

Petitioner started his police career at Auburn, where he was hired as a patrolman. TR, p. 8-9. He left as Chief of Police. TR, p. 9. He was then a Deputy for a year and a half with the Sangamon County Sheriff's office while trying to get onto the State Police. TR, p. 9. He was hired by the State Police in November of 1977 and retired in July of 2003. TR, p. 9.

Since retiring from the State Police, Petitioner worked at Homeland Security through Lockheed Martin and Homeland Security Corporation recertifying TSA screeners. TR, p. 9. After that contract, he began working security at the Illinois House of Representatives. TR, p. 9. He began working for the House of Representatives in about 2007, and was working there at the time of the accident. TR, p. 10.

As a security officer for Respondent, his duties were to maintain order within the House chambers. TR, p. 10. He would hold security for the committee rooms and provide security for dignitaries who came to speak. TR, p. 10-11.

Physically, he would need to direct people, including occasionally removing people physically. TR, p. 11-12. Once out of the building Capitol Police or State Police would take over. Tr, p. 12. He had to be prepared to get into a full, physical confrontation. TR, p. 12. He estimated that in his years working for Respondent he had to physically remove people 30-40 times. TR, p. 36.

On January 11, 2017, the Illinois House was holding their swearing in ceremony at the University of Illinois Springfield auditorium. TR, p. 12. Petitioner was assigned to provide security there and keep out people who did not belong in certain areas. TR, p. 13.

On that day, he was walking to the north end of campus, where he was to report to the lower unit, so he walked up the sidewalk on the east side of the auditorium. TR, p. 13. There was a stairwell just to the north of the lower unit, and he was walking down the stairs with a coworker when he slipped on a patch of ice and went flying, landing on his head and shoulder. TR, p. 13.

Petitioner reviewed a series of photographs, entered into evidence as Petitioner's Exhibit 9, which he testified depicted injuries he sustained to head, left arm and left hand. TR, p. 13. He testified the photographs were taken at Memorial Medical Center shortly after the accident, and that they fairly and accurately depict the physical injuries he sustained as a result of the accident. TR, p. 13-14. He testified he sustained a contusion to his head, shattered his left elbow, and injured a nerve into his left hand. TR, p. 14.

Following the accident, Petitioner presented to the Memorial Medical Center ("MMC") Emergency Department and reported that he had slipped and fallen down stairs, landing on his left arm and face. PX 7. He complained of pain in his left arm and face, and an abrasion was noted on his left knee. PX 7. He was examined

by resident Dr. Sven Steen, who noted: left facial abrasions; left upper extremity tenderness to palpation from the midhumerus to the elbow; and a left knee abrasion with slight tenderness. PX 7.

Dr. Steen ordered x-rays of Petitioner's left knee, left forearm, left elbow and left humerus, and CT scans of chest/abdomen/pelvis, sinus/facial bones, head, cervical spine, thoracic spine and lumbar spine. PX 7. The x-rays were reviewed by radiologist Dr. Kevin Coakley. PX 7. The x-ray of the left knee was negative for acute injury. PX 7. With respect to the left arm x-rays, Dr Coakley noted a comminuted fracture of the left radial head and neck with a dislocation of a portion of the radial head laterally. PX 7. He also noted soft tissue swelling in the distal left upper arm and over the dorsomedial aspect of the proximal forearm. PX 7. The CT scans were reviewed by radiologists Dr. Marissa Blitstein and resident Dr. Lauren Thompson. PX 7. The scans of the chest/abdomen/pelvis and of the spine were negative for acute injury. PX 7. The CT scans of the sinus/facial bones and head showed superficial soft tissue swelling/contusion in the left frontal/supraorbital region. PX 7.

While at MMC, Petitioner also had a consultation with orthopedic surgeon Dr. Benjamin Stevens. PX 7. Dr. Stevens noted he felt immediate pain after falling down concrete steps onto his left elbow, and that he noticed tingling in his 4th and 5th digits. PX 7. Dr. Stevens noted he had sustained a left radial head fracture. PX 7. He was placed in an immobilizer splint and a sling, and was advised to be non-weightbearing on the left arm. PX 7. Petitioner was provided educational materials on elbow fractures, concussion and abrasions, prescribed pain medications, and discharged home with instructions to follow up with an orthopedic specialist. PX 7.

On January 16, 2017, Petitioner presented to Springfield Clinic for a follow up with orthopedic surgeon Dr. Matthew Gardner. PX 1. On examination of the left elbow, Dr. Gardner noted Petitioner was fairly swollen down into his hand, that he was tender to palpation, and that he had pain with any range of motion. PX 1. Dr. Gardner recommended surgical intervention. PX 1.

Petitioner presented to MMC on January 26, 2017, wherein Dr. Gardner performed a left radial head replacement arthroplasty and primary repair with suture anchor of the lateral collateral ligament. PX 2. Dr. Gardner noted pre and postoperative diagnoses of a left comminuted radial head fracture and a left lateral collateral ligament rupture. PX 2. He also noted that he was proceeding with the replacement procedure rather than with an open reduction internal fixation as that procedure would not produce a good result due to the number of comminuted fragments. PX 2.

On February 8, 2017, Petitioner followed up postoperatively with Dr. Gardner. PX 1. He rated his pain at 5/10 and complained of numbness in an ulnar nerve distribution. PX 2. Dr. Gardner referred him to physical therapy. PX 1. He participated in physical therapy at Springfield Clinic from February 10, 2017 through May 24, 2017. PX 3.

Petitioner continued to follow up postoperatively with Dr. Gardner's office, and on April 5, 2017 Dr. Gardner noted Petitioner complained of shooting pain down the elbow, more like a nerve pain, which Dr. Gardner again noted was in the ulnar nerve distribution. PX 1. With respect to he left radial head replacement, Dr. Gardner noted he was doing fairly well. PX 1. He noted he would speak to orthopedic specialist Dr. Jianjun Ma regarding his nerve symptoms. PX 1.

On April 14, 2017, Petitioner presented to Springfield Clinic for an evaluation with Dr. Ma. PX 1. He complained of numbness and tingling to his left ring and small fingers which had not improved over the past

month. PX 1. He also reported difficulty closing these fingers. PX 1. Dr. Ma discussed surgical intervention and scheduled him for an EMG/nerve conduction study to further evaluate his symptoms. PX 1.

Petitioner presented to Springfield Clinic on May 9, 2017 for the nerve studies. PX 1. The studies were reviewed by neurologist Dr. Cecile Becker, who noted findings consistent with: a mild to moderate median mononeuropathy at the left wrist (carpal tunnel syndrome); a severe ulnar mononeuropathy in the left forearm and wrist with demyelination but also significant axonal loss; a moderate radial mononeuropathy at the spiral grove; and a possible superimposed cervical radiculopathy. PX 1.

Petitioner last followed up with Dr. Gardner on May 17, 2017. PX 1. Dr. Gardner advised him to continue strength and range of motion exercises, and opined he could follow up on an as needed basis. PX 1.

On May 19, 2017, Petitioner followed up with Dr. Ma regarding the results of the EMG/nerve conduction studies. PX 1. He diagnosed Petitioner with carpal tunnel, cubital tunnel, and Guyon syndrome on the left. PX 1. He recommended left cubital tunnel release and ulnar nerve anterior transposition, left carpal tunnel release, and left Guyon's canal ulnar nerve release procedures. PX 1. The recommended procedures were performed by Dr. Ma on June 1, 2017. PX 4.

Petitioner followed up at Springfield Clinic postoperatively on June 15, 2017 and reported that his pain had resolved and that he was beginning to regain sensation to the fingers on his left hand. PX 1. He was placed on 5-pound lifting restrictions and advised to follow up with Dr. Ma in two weeks. PX 1. He followed up with Dr. Ma on June 30, 2017 and reported numbness, tingling, some shocking sensation, and stiffness of the left hand. PX 1. Dr. Ma recommended he continue with a home exercise program and was referred to occupational therapy. PX 1. Dr. Ma explained nerve regeneration could take 6 months to a year and instructed him to follow up in two weeks. PX 1.

On July 3, 2017, Petitioner presented to Springfield Clinic Occupational Therapy for an initial evaluation. PX 5. He participated in therapy through August 22, 2017, at which time it was recommended that he be transferred to a work hardening program. PX 5.

Petitioner next followed up with Dr. Ma on September 1, 2017 and reported that he still had numbness and tingling in his left hand, though his range of motion had improved. PX 1. Dr. Ma recommended he continue a home exercise program and referred him for additional therapy. PX 1. Petitioner participated in work conditioning at Memorial Industrial Rehabilitation from September 4, 2017 through October 25, 2017. PX 6.

On October 27, 2017, Petitioner followed up with Dr. Ma and reported that his strength had improved with therapy, but that his still had numbness and tingling in his left hand, as well as sharp, intermittent pain. PX 1. Dr. Ma advised him to continue with a home exercise program and to follow up. PX 1.

Petitioner continued to follow up with Dr. Ma through July 13, 2018. PX 1. He testified he had not returned to work up through that visit. TR, p. 24. He reports his left elbow pain had improved, though his left hand remained numb and tingly. PX 1. He also complained of muscle atrophy and weakness. PX 1. Dr. Ma placed him at maximum medical improvement, and opined that he would have to learn to live with weakness, numbness and tingling in the left upper extremity for a long time. PX 1.

Petitioner testified Dr. Ma did not address his restrictions or capabilities at the July 13, 2018 office visit, and so later called Dr. Ma's office to clarify what his abilities were. TR, p. 25. Dr. Ma referred him for a functional capacity evaluation. TR, p. 25.

On March 11, 2020, Petitioner presented to Memorial Industrial Rehabilitation for a functional capacity evaluation. PX 8. He was evaluated by Physical Therapist Valerie Cain, who noted he was willing to work to his maximal abilities and demonstrated maximal effort on all test items. PX 8. With respect to the left hand, PT Cain noted true limitations in left gripping, pinching (tip pinch, palmar pinch, and lateral pinch), and fine motor coordination. PX 8. He was noted to demonstrate abilities in the mid-range of the medium physical demand level for below the waist lifts and carries and in the light physical demand level for above the shoulder lifts. PX 8.

Following the functional capacity evaluation, Petitioner presented to Dr. Ma's office on March 17, 2020 and complained of ongoing left hand numbness, tingling and intermittent, sharp pain. PX 1. Dr. Ma noted he could return to work and perform activities at the medial physical demand level for below the waist, and at the light physical demand level above the shoulder. PX 1. Dr. Ma again advised that Petitioner would have to learn to live with numbness, tingling and weakness in his left hand. PX 1.

Petitioner testified he did not believe he could return to work under those limitations. TR, p. 27. He testified to ongoing extreme weakness in this left hand, and that the 4th and 5th fingers lock up. TR, p. 28. He testified he has episodes where he will drop items because his strength is gone. TR, p. 28. He testified the muscle between his thumb and index finger is gone and will never come back. TR, p. 28.

Petitioner testified the replacement in his left elbow prevents full extension. TR, p. 29. He testified that most of the time he lacks the strength to perform certain tasks. TR, p. 29-30. He testified he cannot hold a golf club, and has difficulty lifting and carrying groceries with his left. TR, p. 3-32. He told a story about dropping a cut of tea, and testified he did not know it was slipping because he could not feel it. TR, p. 32.

He testified he would like to go back to working security, but that he would be concerned about getting himself or someone else hurt because he cannot carry his end of the workload. TR, p. 33. He testified he believes he is extremely limited in the things he can do; even typing would be an issue because his fingers do not move like they are supposed to. TR, p. 33. He testified that if he raises his arm up the wrong way it feels like someone put a knife in the muscle in the back of his arm. TR, p. 34. He testified it hurts every day. TR, p. 35.

Petitioner testified he had not returned to work since the accident. TR, p. 36.

CONCLUSIONS OF LAW

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

First, the Arbitrator notes that Respondent does not dispute that Petitioner sustained an accident which arose out of and in the course of his employment. With respect to Petitioner's current condition of ill-being, the only dispute is whether Petitioner's condition of ill-being was causally related to the injury after he had been placed at maximum medical improvement by Dr. Ma on July 13, 2018.

Respondent does not dispute that Petitioner's condition of ill-being at his July 13, 2018 Springfield Clinic office visit with Dr. Ma was causally related to the workplace injury. At this office visit, Dr. Ma placed Petitioner

at maximum medical improvement and opined that Petitioner would have to learn to live with weakness, numbness and tingling in the left upper extremity for a long time. PX 1.

Petitioner testified Dr. Ma did not address his restrictions or capabilities at the July 13, 2018 office visit, and so he later called Dr. Ma's office to clarify what his abilities were. TR, p. 25. Dr. Ma referred him for a functional capacity evaluation at that time. TR, p. 25.

On March 11, 2020, Petitioner presented to Memorial Industrial Rehabilitation for a functional capacity evaluation. PX 8. With respect to the left hand, PT Cain noted true limitations in left gripping, pinching (tip pinch, palmar pinch, and lateral pinch), and fine motor coordination. PX 8. These limitations are consistent with Petitioner's complaints throughout his treatment with Dr. Ma, and are consistent with the symptoms Dr. Ma opined, on July 13, 2018, that he would have to live with for a long time. Petitioner was noted to demonstrate abilities in the mid-range of the medium physical demand level for below the waist lifts and carries and in the light physical demand level for above the shoulder lifts. PX 8.

Respondent has offered no evidence or medical opinion which disputes that these limitations were related to Petitioner's January 11, 2017 left elbow injury.

Following the functional capacity evaluation, Petitioner presented to Dr. Ma's office on March 17, 2020 and complained of ongoing left hand numbness, tingling and intermittent, sharp pain. PX 1. These complaints are likewise consistent with Petitioner's complaints throughout his treatment with Dr. Ma, and are consistent with the symptoms Dr. Ma opined, on July 13, 2018, that he would have to live with for a long time. Additionally, this office visit was clearly a follow up regarding the results of the FCE. Dr. Ma concurred with the results of the FCE and placed Petitioner on work restrictions at the medial physical demand level for below the waist, and at the light physical demand level above the shoulder. PX 1.

Respondent has likewise offered no evidence or medical opinion which disputes that these complaints or restrictions were related to Petitioner's January 11, 2017 left elbow injury.

As such, the testimonial and medical evidence presented in this case clearly support a finding that Petitioner's current condition of ill-being, including his condition of ill-being documented in the records of the March 11, 2020 FCE and March 17, 2020 office visit with Dr. Ma, is causally related to the workplace injury. No evidence had been presented to the contrary.

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

Petitioner has submitted medical bills as Exhibit 10. The only bills set forth in Plaintiff's Exhibit 10 which are in dispute are those for the March 11, 2020 Functional Capacity Evaluation at Memorial Industrial Rehabilitation, and those for the March 17, 2020 Springfield Clinic office visit.

For the reasons set forth above, these bills represent reasonable and necessary charges incurred by Petitioner for medical services which were causally related to his workplace accident.

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 10, directly to the providers, according to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Further,

Respondent shall reimburse Petitioner $379.08 for out of pocket medical expenses related to the March 11, 2020 FCE bill.

Issue K: Is the Petitioner entitled to temporary total disability benefits?

Petitioner claims he is due temporary total disability benefits from the day following the accident, January 12, 2017, through July 13, 2018, at which time he was placed at maximum medical improvement. This represents a period of 78 and 1/7 weeks. Respondent does not dispute that Petitioner is due these benefits.

Respondent is ordered to pay Petitioner $120.19 per week for a period of 78 and 1/7 weeks, representing temporary total disability benefits from January 12, 2017 through July 13, 2018.

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

For accidents occurring after September 1, 2011, the Arbitrator must look to the five-factor test in determining permanent partial disability. With regards to the first factor, no AMA impairment rating has been presented into evidence. The Arbitrator therefore gives this factor no weight.

As to the second factor, nature of the employment, Petitioner testified as part of his job duties with Respondent, he would need to direct people, including occasionally removing people physically. He estimated that in his years working for Respondent he had to physically remove people 30-40 times. He testified he had to be prepared to get into a full, physical confrontation. On March 17, 2020, Dr. Ma placed Petitioner on permanent restrictions at the medial physical demand level for below the waist, and at the light physical demand level above the shoulder. Petitioner's job duties do not fall within these restrictions. The Arbitrator therefore gives this factor moderate weight.

With regards to the third factor, age, Petitioner was 65 years old on the date of his accident. Petitioner will likely live for a number of years and continue to suffer ongoing limitations, as set forth in factor five, during that period. As such, the Arbitrator gives this factor minor weight.

With regards to the fourth factor, future earning capacity, Petitioner has not returned to work for Respondent, and testified he could not return to work under the limitations provided by Dr. Ma on March 17, 2020. He testified to ongoing limitations, and that he would like to go back to working security, but that he would be concerned about getting himself or someone else hurt because he cannot carry his end of the workload. He testified he believes he is extremely limited in the things he can do; even typing would be an issue because his fingers do not move like they are supposed to. The Arbitrator therefore gives this factor minor weight.

Finally, with regards to the fifth factor, evidence of disability corroborated by treatment records, a CT scan taken of Petitioner's sinus/facial bones was taken at the initial MMC Emergency Department visit on January 11, 2017, which revealed superficial soft tissue swelling/contusion in the left frontal/supraorbital region. PX 7.

With respect to his left arm, x-rays were taken of Petitioner's left forearm, left elbow and left humerus at the initial MMC Emergency Department visit, which revealed a comminuted fracture of the left radial head and neck with a dislocation of a portion of the radial head laterally, as well as soft tissue swelling in the distal left upper arm and over the dorsomedial aspect of the proximal forearm. PX 7.

While at MMC, Petitioner also had a consultation with orthopedic surgeon Dr. Benjamin Stevens. PX 7. Dr. Stevens noted he felt immediate pain after falling down concrete steps onto his left elbow, and that he noticed tingling in his 4th and 5th digits. PX 7. Dr. Stevens noted he had sustained a left radial head fracture. PX 7.

After discharge from MMC, Petitioner began follow up treatment with Dr. Gardner at Springfield Clinic. Dr. Matthew Gardner recommended surgical intervention, and Petitioner presented to MMC on January 26, 2017 for left radial head replacement arthroplasty and primary repair with suture anchor of lateral collateral ligament procedures. Dr. Gardner noted pre and postoperative diagnoses of a left comminuted radial head fracture and a left lateral collateral ligament rupture. PX 2. Dr. Gardner also noted that he was proceeding with the replacement procedure rather than with an open reduction internal fixation as that procedure would not produce a good result due to the number of comminuted fragments. PX 2.

Petitioner followed up with Dr. Gardner postoperatively on February 8, 2017 and complained of numbness in an ulnar nerve distribution. Dr. Gardner ultimately referred him to Dr. Ma for evaluation of ulnar nerve symptoms.

On April 14, 2017, Petitioner presented to Springfield Clinic for an evaluation with Dr. Ma complaining of numbness and tingling to his left ring and small fingers which had not improved over the past month. PX 1. He also reported difficulty closing these fingers. PX 1. Dr. Ma discussed surgical intervention and scheduled him for an EMG/nerve conduction study to further evaluate his symptoms. PX 1.

Petitioner presented to Springfield Clinic on May 9, 2017 for the nerve studies. PX 1. The studies were reviewed by neurologist Dr. Cecile Becker, who noted findings consistent with: a mild to moderate median mononeuropathy at the left wrist (carpal tunnel syndrome); a severe ulnar mononeuropathy in the left forearm and wrist with demyelination but also significant axonal loss; a moderate radial mononeuropathy at the spiral grove; and a possible superimposed cervical radiculopathy. PX 1.

On May 19, 2017, Petitioner followed up with Dr. Ma regarding the results of the EMG/nerve conduction studies. PX 1. He diagnosed Petitioner with carpal tunnel, cubital tunnel, and Guyon syndrome on the left. Dr. Ma performed left cubital tunnel release and ulnar nerve anterior transposition, left carpal tunnel release, and left Guyon's canal ulnar nerve release on June 1, 2017. PX 4.

Petitioner continued to follow up with Dr. Ma through July 13, 2018. PX 1. He testified he had not returned to work up through that visit. TR, p. 24. He reports his left elbow pain had improved, though his left hand remained numb and tingly. PX 1. He also complained of muscle atrophy and weakness. PX 1. Dr. Ma placed him at maximum medical improvement, and opined that he would have to learn to live with weakness, numbness and tingling in the left upper extremity for a long time. PX 1.

Following the July 13, 20120 office visit, Petitioner contacted Dr. Ma's office regarding his restrictions and capabilities, and was referred for a functional capacity evaluation. TR, p. 25. Petitioner attended the FCE on March 11, 2020, and with respect to the left hand, limitations were noted in left gripping, pinching (tip pinch, palmar pinch, and lateral pinch), and fine motor coordination. PX 8. Petitioner followed up with Dr. Ma on March 17, 2020, and Dr. Ma noted he could return to work and perform activities at the medial physical demand level for below the waist, and at the light physical demand level above the shoulder. PX 1. Dr. Ma again advised that

Petitioner would have to learn to live with numbness, tingling and weakness in his left hand. PX 1. The Arbitrator gives great weight to the fifth factor.

Taking the evidence and the five factors into consideration, the Arbitrator finds that Petitioner has sustained a 40% loss of the loss of use of the left arm and a 20% loss of use of the left hand pursuant to Sections 8(e)(10) and 8(e)(9), respectively. Respondent is ordered to pay Petitioner $120.19/week for a period of 141.4 weeks.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC036027
Case Name	ROWSEY,DONALD v. KNAPHEIDE MANUFACTURING CO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0415
Number of Pages of Decision	16
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	PHILIP BARECK
Respondent Attorney	Terry Schroeder

DATE FILED: 8/16/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DONALD ROWSEY,

Petitioner,

vs. NO: 17 WC 36027

KNAPHEIDE MANUFACTURING CO.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner proved that a stipulated accident on October 17, 2017 caused a current condition of ill-being of his right shoulder. He awarded Petitioner 49&2/7 weeks of temporary total disability benefits, $42,306.75 in medical expenses, and 62.5 weeks of permanent partial disability benefits representing loss of 12.5% of the person-as-a-whole. The Commission agrees with the Arbitrator's analysis and findings regarding the issues of causal connection, medical expenses, and the award of temporary total disability benefits. Therefore, the Commission affirms and adopts those portions of the Decision of the Arbitrator and the associated awards of temporary total disability benefits and medical expenses. However, the Commission modifies the Decision of the Arbitrator to increase the permanent partial disability award.

Petitioner worked for Respondent prepping truck bodies for painting. He was 59 years old at the time of the stipulated accident. On October 17, 2017, he was pushing a particularly large truck body on casters with co-workers, to the prepping area. He testified he felt immediate, burning, pain in his right shoulder. He continued to work his shift, but could not use his right arm much, used his left arm to complete his required tasks, and asked for assistance from co-workers when needed. Over the next couple of weeks, Petitioner's shoulder did not get better but worsened. He failed conservative treatment, and on August 13, 2018, Dr. Greatting performed reverse total arthroplasty of the right shoulder.

On January 25, 2019, Petitioner had a Functional Capacity Evaluation ("FCE") in which he was found to give full effort in all tests. He was determined to be able to function at the light physical demand level and he showed significant deficiencies in range of motion and strength. Petitioner described his work as "physical" in which had to push/pull more than 50 pounds regularly. Petitioner testified that currently he was on Social Security disability. He became eligible retroactively to November 11, 2017 and had been receiving pension benefits from Respondent for about a year before arbitration. Petitioner testified that currently, he had 5-6/10, pain sometimes worse. His shoulder was "not near the same, [he] can't hardly do anything over shoulder height, can't hardly lift" anything.

In arriving at his permanent partial disability award, the Arbitrator found Petitioner credible and believable in testifying about his ongoing pain, decreased range of motion, limitations, and weakness of his right shoulder and that all these deficits were corroborated by the medical records. The Arbitrator also noted that Petitioner had provided full effort in the FCE and was placed on substantial permanent work restrictions, which clearly precluded Petitioner from returning to work in his previous physically demanding job. In explaining his award of 62.5 weeks of permanent partial disability benefits representing loss of 12.5% of the person-as-a-whole, the Arbitrator gave greater weight to his inability to return to work in his physically strenuous job and to evidence of disability supported by the record. He gave lesser weight to his advanced age. Finally, the Arbitrator also gave lesser weight to the possible loss of income, noting that Petitioner had retired and received social security disability and pension income.

The Commission generally agrees with the Arbitrator about the relevant factors in this claim to determine Petitioner's appropriate permanent partial disability benefits. However, the Commission finds that these factors point to a higher award than 12.5% loss of the person-as-a-whole. Specifically, we note that by precluding Petitioner from returning to work at his prior job, the work injury resulted in Petitioner's loss of trade. The Commission also notes prior decisions of the Commission for shoulder arthroplasties in which the claimant was awarded permanent partial disability benefits in excess of that awarded in the instant claim. In particular, in *Gregory v. Caterpillar*, 16 I.W.C.C. 561, the Arbitrator awarded Petitioner a permanent partial disability award representing loss of the use of 30% of the person-as-a-whole. The Commission modified the award to 25% of the person-as-a-whole. There, the claimant was of similar age (64) at the time of his injury as Petitioner and his permanent work restrictions were similar to those imposed on Petitioner.

Based on the entire record before us and assessment of the statutory factors to determine permanent partial disability awards, the Commission finds an award of 125 weeks representing loss of the use of 25% of the person-as-a-whole is appropriate here. Accordingly, the Commission modifies the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $633.76 per week for a period of 47&2/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $$42,306.75 for medical expenses pursuant to §8(a) of the Act, subject to the applicable medical fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner pay Petitioner the sum of $570.38 for a period of 125 weeks, because the injury he sustained resulted in the loss of 25% of the use of the person-as-a-whole pursuant to §8.1b of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75.000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 16, 2021

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

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

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

DLS/dw
O-6/22/21
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0415

ROWSEY, DONALD
Employee/Petitioner

Case# **17WC036027**

KNAPHEIDE MANUFACTURING COMPANY
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:

0293 KATZ FRIEDMAN EAGLE ET AL
PHILLIPA BARECK
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0000 RUSIN & MACIOROWSKI LTD
TERRY SCHROEDER
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Donald Rowsey
Employee/Petitioner

v.

Knapheide Manufacturing Company
Employer/Respondent

Case # **17** WC **36027**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **October 8, 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 **10/17/2017**, 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 **$49,433,28**; the average weekly wage was **$950.64**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services. See Appendix A, attached.

Respondent shall be given a credit of **$10,508.85** for TTD, **$-** for TPD, **$-** for maintenance, and **$-** for other benefits, for a total credit of **$10,508.85**. See Appendix A, attached.

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

ORDER

Medical Benefits
Respondent shall pay reasonable and necessary medical services of $42,306.75, as provided in Sections 8(a) and 8.2 of the Act. See Appendix A, attached.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $633.76/week for 49-2/7 weeks, commencing 2/28/2018 through 2/7/2019, as provided in Section 8(b) of the Act. See Appendix A, attached.

Permanent Partial Disability with 8.1b language
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 Prepper in the Paint Department which was a physical and strenuous position at the time of the accident and that he *is* not able to return to his full duties because of his permanent restrictions. The Arbitrator notes that Petitioner is no longer employed by Respondent, but his employment was classified as heavy factory work, therefore, the Arbitrator gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Because of his advanced age, 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 was terminated after the accident and is currently drawing Social Security Disability benefits and his Pension, the Arbitrator therefore gives *lesser* 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 underwent a reverse arthroplasty/shoulder replacement to his dominant arm which resulted in permanent restrictions and limitations. Because Petitioner's complaints and limitations are supported by the treating records, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of Petitioner's person as a whole pursuant to §8(d)2 of the Act.

See Appendix A – Findings of Facts and Conclusions of Law, 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

11/24/20
Date

DEC 2 - 2020

Donald Rowsey v. Knapheide Manufacturing Company
Case Nos. 17 WC 36027
Appendix A

Findings of Facts and Conclusions of Law

On October 17, 2017, Petitioner testified that he worked for Respondent as a Prepper in the Paint Department and had been employed by the Respondent since March of 1997. Petitioner testified that he is right hand/arm dominant. As a Prepper, Petitioner was required to repair bodies using various tools such as welding guns, welders, scrappers and sanders to prepare the bodies for the paint area. Petitioner testified that the Prepper position required Petitioner to push, pull and lift over 50 pounds on a regular basis and required him to perform overhead work, throughout the workday, as needed.

After prepping the body for painting, Petitioner testified that he and several coworkers pushed the body, which was sat on rollers, into the paint department. A body was a galvanized metal truck frame which weighed anywhere from 1 ton to several tons. Petitioner testified that he and his coworkers would manually push the body by standing in back of the body and leaning into it. The body would be pushed on concrete and was strenuous because of the weight and at times there would be debris on the ground.

On October 17, 2017, Petitioner testified that he began work at 6:00 a.m. He testified that he did not have any issue or problem with reference to his right shoulder and was able to perform all of his work activities as a Prepper/Paint Department. That morning, after prepping, a large, 2 ton body, Petitioner testified that he, along with coworkers, Kevin Mathews and Robert Benge pushed the large metal body into the paint area. Petitioner testified that the body was on a cart with wheels and he and his two coworkers positioned themselves in back of the metal body and began pushing with force against the large frame. Petitioner had his arms positioned in front of him, approximately shoulder height on the frame, and after several feet of pushing, Petitioner testified that his right arm/shoulder turned and twisted inward and he noticed a burning sensation in his right shoulder. He testified that he immediately was unable to continue pushing and notified his coworkers.

Petitioner testified that years prior to October 17, 2017, he had a right shoulder condition. In 2002, he underwent right shoulder surgery in Columbia, Missouri. He recalled treating for approximately one year and was released full duty in approximately 2004. Between 2005 and October 16, 2017, the day before the accident, Petitioner testified that he did not notice anything unusual with reference to his right shoulder, did not see a physician with reference to his right shoulder, did not need restrictions with reference to his right shoulder, nor did not take medication with reference to his right shoulder.

After the accident, Petitioner testified that he reported the accident to his supervisor and they completed an accident report. Petitioner offered the Employee's First Report of Injury, dated October 17, 2017, into evidence. The First Report of Injury notes that at 8:15 a.m. he, along with Kevin and Bob were pushing a "Big Body and my Right shoulder turn and is burning this is the same shoulder I had fix about fourteen years ago." (PX1). Petitioner testified that after the accident he continued working but noticed right shoulder pain and difficulties performing his job

duties. Petitioner testified that he was hoping that his right shoulder symptoms would dissipate but performing his physical and overhead activities continued to cause right shoulder pain. Therefore, Petitioner testified that he made an appointment at the Knapheide Clinic/CareLynx/WeCare and saw Dr. Richardson. (PX2). According to Dr. Richardson's records, Petitioner had a right shoulder injury from pushing a heavy truck body and felt a "pop", burning and weakness in his arm. Dr. Richardson recommended an MRI. (PX2).

On November 30, 2017, Petitioner was seen at the Quincy Medical Group for an MRI and the indication notes "Superior right shoulder pain for 6 weeks. Injury at work. History of right shoulder surgery 13 years ago...." (PX2, PX3). The MRI revealed a full-thickness tear of a supraspinatus tendon along with a rupture of the long head of the biceps tendon. (PX2, PX3). The MRI also revealed moderate shoulder joint effusion. (PX2, PX3). Following the MRI, Petitioner testified that Dr. Richardson referred him to the Quincy Medical Group and Dr. Andrews.

On December 7, 2017, Petitioner was seen by Dr. Andrews for sudden burning pain in the right shoulder and weakness pertaining to an injury to his right shoulder on October 17, 2017 from pushing a huge truck body. (PX3). Dr. Andrews' record indicated that he referred Petitioner to Dr. Greatting for ongoing right shoulder treatment. (PX3).

On January 17, 2018, Petitioner testified he was seen by Dr. Greatting. According to Dr. Greatting's records, Petitioner had a prior rotator cuff repair performed in 2002 or 2003 and thereafter was feeling pretty normal. (PX4). Then on October 17, 2017, Petitioner was helping push a truck body into the paint chamber and experienced burning in his right shoulder, followed by pain, decreased motion and weakness in his shoulder. (PX4). After performing an examination, Dr. Greatting concluded that Petitioner "had a significant incident occur on October 17th, which either caused some further tearing or damage to his rotator cuff or significantly exacerbated a pre-existing condition...." (PX4 – January 17, 2018). Petitioner testified that he followed up with Dr. Greatting on February 28, 2018 and was provided restrictions with reference to his right shoulder which included no lifting over 10 pounds from floor to waist, 5 pounds above the waist, no lifting above his shoulder and no climbing. (PX4). Dr. Greatting recommended a right shoulder reverse arthroplasty procedure to treat the injury. (PX4)..

On May 2, 2018, Petitioner was examined by Dr. Kostman at Respondent's request pursuant to Section 12 of the Act. According to Dr. Kostman's report, he did not believe the findings of chronic right shoulder rotator cuff tear long head of the biceps tendon rupture, and osteoarthritis were "specifically related to his injury as described on October 17, 2017". (RX1). On June 8, 2018, Dr. Kostman wrote a record review letter and indicated that Dr. Greatting's recommendation of a reverse shoulder arthroplasty is not secondary to the incident of October 17, 2017 nor necessarily based on an aggravation of the underlying condition. (RX2).

Respondent deposed Dr. Kostman. Dr. Kostman opined, based upon a reasonable degree of medical certainty, that the reverse shoulder arthroplasty recommended surgery did not have any relationship to the October 17, 2017 work accident. (RX3 @ p. 15). Rather, Dr. Kostman opined that Petitioner had a long-standing rotator cuff tear and degenerative change in the shoulder which dated back to the original surgery in 2002. (RX3 @ p. 15). On cross-

examination, Dr. Kostman admitted that Respondent never provided him a job title or job description of Petitioner's job duties for Respondent, did not know how long Petitioner had worked for Respondent prior to the October 17, 2017 accident, acknowledged that Petitioner told him after the 2002 surgery and the completion of physical therapy he did not have any difficulty with his right shoulder until the October 17, 2017 accident, had no medical records from 2003 through October 17, 2017 that would question Petitioner's description that he was doing well with reference to his right shoulder between 2003 and October 17, 2017, was not aware of Petitioner having any treatment pertaining to his right shoulder between 2003 and October 17, 2017, nor restrictions or medication pertaining to his right shoulder. (RX3 @ pp 16, 17, 19, 22, 23, 24). Additionally, Dr. Kostman agreed that he never reviewed the accident report completed in this case but acknowledged that Petitioner became symptomatic on October 17, 2017 when pushing the truck body. (RX3 @ pp 24, 27-28). The doctor admitted, based on the history he was provided, that pushing the truck body on October 17, 2017 caused the shoulder pain and he had no reason to doubt that. (RX3 @ pp 31-32). Dr. Kostman admitted that he had not seen the August 13, 2018 operative report concerning the reverse right shoulder arthroplasty and did not even know that Petitioner underwent shoulder surgery in August of 2018. (PX3 @ pp 34-35). Dr. Kostman indicated that the medical treatment Petitioner received through the IME date of May 9, 2018 was reasonable and necessary. (RX3 @ p. 36).

Petitioner testified that after Dr. Kostman's examination, Respondent terminated workers' compensation benefits including his weekly TTD and medical care.

On August 13, 2018, Petitioner testified that he underwent a right shoulder reverse arthroplasty performed by Dr. Greatting. (PX4). According to the history noted in the operative report, Petitioner had a previous right rotator cuff surgery years earlier and then subsequently had a work-related injury to his shoulder with marked increase in pain, weakness and decreased range of motion. (PX4). The surgical records indicated that the surgery included a BIOMET Comprehensive Reverse Shoulder System glenosphere mini base plate, humeral tray with locking ring 44-mm standard, humeral bearing 44mm with 36-mm curvature diameter standard. (PX4 – August 13, 2018 operative report). Following surgery, Petitioner testified he underwent physical therapy and continued to treat with Dr. Greatting through January 2, 2019. (PX4, PX7). During this recovery, Petitioner testified that he was taken off work until Dr. Greatting recommended a functional capacity evaluation (FCE) on January 2, 2019. (PX4).

On January 25, 2019, Petitioner was seen at Memorial Industrial Rehabilitation for an FCE test. (PX5). The FCE noted that Petitioner demonstrated cooperative behavior and was willing to work to maximum abilities in all test items. Under consistency of performance, the therapist noted that Petitioner gave "maximal effort" on all test items as evidenced by predictable patterns of movement. (PX5). The FCE revealed a decreased positional tolerance for weight elevated work, decreased low work positional tolerances for crouching and decreased right shoulder active range of motion and strength accompanied by pain reports. (PX5). The FCE test concluded that Petitioner was limited to the Light Work Level and recommended the following restrictions: no lifting over 20 pounds occasionally waist to floor, and waist to crown, no carrying over 20 pounds, no regular lifting above the shoulder with the right arm, no climbing ladders on a regular basis, no pushing or pulling over 50 pounds and no impact activities. (PX5). After the FCE test, Petitioner testified he had a final appointment with Dr. Greatting. On

February 7, 2019, Dr. Greatting's records noted that Petitioner's shoulder pain was significantly improved and that the FCE results helped determine his permanent restrictions. (PX4). Petitioner testified that he was released from Dr. Greatting's care at that time with permanent restrictions consistent with the FCE.

On July 31, 2019, Petitioner testified he was examined at his attorney's request by Dr. Gregory Nicholson at Midwest Orthopedics at Rush pursuant to Section 12. (PX6). After reviewing the history, accident report and medical records, Dr. Nicholson explained "[c]learly, he had a preexisting condition, advanced rotator cuff tear arthropathy with adaptive changes. However, this was clinically quiescent and asymptomatic and he is able to do his job." (PX6). Based upon a reasonable degree of medical and surgical certainty, the doctor indicated that the October 17, 2017 accident exacerbated a preexisting condition that was unable to be resolved with conservative management, and therefore the total shoulder arthroplasty was the appropriate operative intervention. (PX6). Moreover, Dr. Nicholson stated that the injury will not allow him to return to the type of work he did before and recommended restrictions for push-pull 25-30 pounds below chest height and lift 8-10 pounds above chest height. (PX6 – IME Report).

Petitioner deposed Dr. Nicholson. Dr. Nicholson testified that he and his medical group are the team physicians for the Chicago Bulls and the Chicago White Sox and he has a sub-specialty in shoulder and elbow treatment. (PX6 @ pp 6-7). Dr. Nicholson noted that Petitioner felt symptomatic relief from the reverse shoulder replacement as the pain had gone down dramatically but he continued to have soreness and crepitus at the time of the examination and noted a well healed deltopectoral incision and a loss of motion in the external rotators but had enough rotation and could elevate the arm to about the average. (PX6 @ pp 17-22). Dr. Nicholson concluded that he had a loss of forward elevation and external rotation in his right arm. (PX6 @ p. 22). Dr. Nicholson, after reviewing the medical records and documentation, opined based on a reasonable degree and medical certainty that the October 17, 2017 accident exacerbated a preexisting condition resulting in the reverse total shoulder arthroplasty. (PX6 @ p. 23). Dr. Nicholson further testified that this will not allow him to return to the type of work he did previously for Respondent and he recommended restrictions in the range of lifting, pushing and pulling 25 to 30 pounds below chest level and lifting 8 to 10 pounds above chest level. (PX6 @ pp 24-25). On cross examination, Dr. Nicholson admitted that someone could have a very severe arthritic condition and not be symptomatic. (PX6 @ pp 32-33).

At arbitration, Petitioner testified that he is no longer employed by Respondent. Petitioner testified he was terminated on or about November 29, 2017 and lost the union arbitration to retrieve his job back but received a recovery from the Department of Labor/OSHA for the termination. Petitioner testified that he is drawing his pension from Respondent and also Social Security Disability benefits. (PX9).

Petitioner testified that he drew temporary total disability benefits from February 28, 2018 through June 2, 2018 but benefits were terminated thereafter. Petitioner testified that after benefits were terminated, he remained off work for his right shoulder injury until Dr. Greatting released him to return to work with permanent restrictions which occurred on February 7, 2019. (PX4). Petitioner also testified that he used his wife's group medical plan to pay for his right shoulder treatment after workers' compensation benefits were terminated. Petitioner testified

that his wife works for the Quincy Public School District and her health insurance was Health Scope that paid the medical bills noted in the bill work up. (PX8). Petitioner also indicated that he had Medicaid which paid a portion of the right shoulder bills along with Meridian Illinois. (PX8). Concerning his right shoulder condition, Petitioner testified that it remains weak and stiff and the pain level is a 5-6 in the morning that improves throughout the day. Petitioner testified that he continues to have problems performing any over shoulder or shoulder height activities because of pain and weakness and notices limitations in his motion. He also noted that his right extremity is weaker than it was before the accident. Petitioner testified that he has not worked since November 29, 2017.

Kevin Mathews (hereafter "Mathews") testified on behalf of Petitioner. Mathews testified that he worked for Knapheide for 23 years and retired on May 13, 2019. During that period of time, Mathews testified he worked with Petitioner in the Paint Department. Mathews testified the Paint Department was located near the prep area where Petitioner worked and he had an opportunity to observe Petitioner on a regular basis. Mathews testified that prior to October 17, 2017, he never noticed Petitioner with any issue or problem with reference to his right shoulder. Mathews indicated that Petitioner's job duties were physical in nature. On October 17, 2017, at approximately 8:15 a.m., Mathews testified that he was pushing a large body into the paint booth with Petitioner and another coworker. Mathews indicated that the body was quite heavy and took a great deal of force with several employees. As they pushed the large body, Mathews testified that Petitioner, after several feet, stopped pushing the body and complained of right shoulder pain. Mathews recalled that Petitioner was unable to resume pushing the body and he noticed that Petitioner continued to have right shoulder issues that day and thereafter. Approximately a week later, Mathews testified he was working in the Paint Booth with Petitioner but Petitioner continued to have difficulties moving his right arm and was doing all of the activities with his left arm which made it problematic to complete the tasks. Therefore, Mathews spoke with his boss, Jamie, to ask that Petitioner be reassigned to a lighter job that did not include overhead shoulder activities. Mathews testified for the period of time he worked with Petitioner through November 29, 2017, he noticed that Petitioner continued to have issues with reference to his right shoulder which prevented him from doing many of the strenuous job activities. He was not aware of Petitioner having any accident or incident with reference to his right shoulder except for the October 17, 2017 work accident.

Mike Daling ("hereafter "Daling") testified on behalf of Respondent. Daling testified that he was the Corporate Safety Manger for Respondent. He testified that there is a powered push cart available to employees to transport the bodies from the prep area into the paint area. This power push cart would make is unnecessary to manually push the bodies. On cross-examination, Daling admitted that Petitioner and his coworkers did not use the power push cart on October 17, 2017 when they manually pushed the body.

After reviewing all of the evidence presented, the Arbitrator makes the following conclusions of law:

In regards to "F" – Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

On October 17, 2017, Petitioner was pushing a heavy 2 ton body frame with Mathews which required a significant amount of force and exertion. After pushing the body for several feet, Petitioner's right shoulder/arm turned and he developed an immediate burning sensation. The accident report and medical records from Quincy Medical Group, Knapheide Clinic, Springfield Clinic/Dr. Greatting and Dr. Nicholson support the conclusion that this accident caused a burning pain in Petitioner's right shoulder, limited Petitioner's ability to perform his job duties and necessitated surgical intervention. On August 13, 2018, Dr. Greatting performed a reverse right shoulder arthroplasty and documented that the accident exacerbated Petitioner's preexisting right shoulder condition. This was also supported by Dr. Nicholson. This is also supported by the temporal sequence of events. The only doctor to deny causation was Respondent's IME doctor, Dr. Kostman. Dr. Kostman believed that the reverse shoulder arthroplasty was related to the 2002 previous surgery. However, Dr. Kostman admitted that Petitioner had no treatment, restrictions, medication, or issues with his right shoulder for over 13 years leading up to the October 17, 2017 accident. It was only after Petitioner was pushing a large truck frame that he developed the right shoulder symptomatology. The Arbitrator finds Petitioner's testimony to be credible, believable and consistent with the medical records and the opinions of Drs. Greatting and Nicholson more persuasive than Dr. Kostman. Therefore, the Arbitrator concludes, based upon a preponderance of the evidence presented, that Petitioner's current right shoulder condition is causally related to the October 17, 2017 work accident.

In regards to "J" – Were the medical services that were provided to Petitioner reasonable and necessary? Has the Respondent paid all the appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

After finding that the right shoulder condition is related to the October 17, 2017 accident, the Arbitrator finds the following medical expenses noted in Petitioner's Exhibit #8 are related to the accident and finds the Respondent liable for the following charges:

1. Advanced Physical Therapy - $4,911.82
2. Memorial Medical Center - $22,484.63
3. Springfield Clinic - $14,910.30

According to Petitioner's Exhibit #8, the charges referenced above are the negotiated rates which have been paid by Health Scope, Meridian and Medicaid. Petitioner is entitled to receive payment for such amounts pursuant to Section 8(a) of the Act totaling $42,306.75.

In regards to "K" – What temporary benefits are in dispute for TTD?, the Arbitrator finds the following facts:

Petitioner was off work from February 28, 2018 through February 7, 2019 representing 49-2/7 weeks. Thereafter, he was released from medical care with permanent restrictions as noted in Dr. Greatting's Springfield Clinic records. After finding causation in this case, as mentioned above, the Arbitrator finds that Petitioner is entitled to TTD benefits for 49-2/7 weeks. Respondent is entitled to a credit for the stipulated past TTD payments totaling $10,508.85 (Petitioner testified that he received TTD benefits from February 28, 2018 through June 2, 2018) leaving a balance of $20,967.90 in TTD benefits due and owing to Petitioner.

In regards to "L" – What is the nature and extent of the injury, the Arbitrator finds the following facts:

Petitioner is right hand dominant. He underwent a right shoulder reverse arthroplasty and the Functional Capacity Evaluation at Memorial Industrial Rehabilitation indicated a maximum effort and a Light Work Level with the following limitations/restrictions: no lifting over 20 pounds occasionally waist to floor, waist to crown, no carrying over 20 pounds, no regular lifting above the shoulder with the right arm, no climbing ladders on a regular basis, no pushing or pulling over 50 pounds, and no impact activities. These restrictions became permanent. Dr. Nicholson agreed Petitioner was in need of permanent restrictions. Petitioner has not gone on a job search since he was released from care on February 7, 2019, rather, he has been receiving Social Security Disability benefits and his pension from Respondent. The Arbitrator finds that Petitioner testified in a credible and believable fashion as to his ongoing right shoulder symptoms and limitations including weakness, pain and limited range of motion as supported by the records. After applying the permanent partial disability factors listed in Section 8.1b noted above, the Arbitrator finds that Petitioner sustained a 12.5% loss to his person as a whole. The parties stipulated to an average weekly wage of $950.64 which renders a permanent partial disability rate of $570.38. Therefore, the Arbitrator awards $35,648.75 in permanency.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC030825
Case Name	MANGIAMELI, THOMAS v. VILLAGE OF HOFFMAN ESTATES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0416
Number of Pages of Decision	52
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Patrick Serowka
Respondent Attorney	Robert Maciorowski

DATE FILED: 8/16/2021

DISSENT

/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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS MANGIAMELI,

Petitioner,

vs. NO: 17 WC 30825

VILLAGE OF HOFFMAN ESTATES,

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, temporary total disability, nature and extent, and "(1) Denied TTD Credit for sick and full paid received during the period of disability (2) Inclusion of studies not offered into evidence and inconsistent with evidentiary findings at issue," and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection as stated below. However, we attach the Decision of the Arbitrator, which is made a part hereof, for the Findings of Fact with the modifications noted below.

Respondent's Motion to Strike Petitioner's Response to Respondent's Statement of Exceptions

We initially address Respondent's motion, filed November 15, 2019, arguing that Petitioner's response brief should be stricken because it exceeded the limits prescribed in Section 9040.70(c)(1) of the Commission Rules, which require that it "shall be written or printed on one side of no more than 20 [pages] or shall contain no more than 5,200 words, whichever is greater…." Petitioner did not file a response to Respondent's motion but, in his brief, wrote, "Petitioner is aware of the size limitations for Statement of Exceptions under the rules. However, the breadth of the evidence and the 43 page decision at arbitration made adherence to this rule not possible." *P-brief at 2*.

Respondent did not cite any precedent to strike Petitioner's response brief. We were unable to find an appellate decision specifically addressing the size limitation of briefs, but take note of the Commission Order in *Perez v. Sonoco Alloyd*, 14WC 17641; 2020 Ill. Wrk. Comp. LEXIS 1134, that addressed a motion to strike due to untimeliness. The Order found:

> After careful consideration, the Commission denies Petitioner's motion. **There is no mechanism in either the Act or the Administrative Rules that allow for the Commission to strike a response to a party's Statement of Exceptions due to an untimely filing**. Furthermore, the Commission has already imposed the appropriate sanction of denying Respondent its requested oral argument due to its failure to timely file its Statement of Exceptions. Pursuant to Section 9040.70(d) of the Rules, the sanction for a party's untimely filing of both a Statement of Exceptions or a Response Brief is identical. 2020 Ill. Wrk. Comp. LEXIS 1134, *2 (12/3/20) (Emphasis added).

Similarly, there is no mechanism to strike a response brief for exceeding the size/page limitation. Although the Rules use the term "shall" in limiting the size of the briefs, there is no explicit penalty for exceeding those page limits. Even in the case of an *untimely* filing, the only penalty is denial of oral arguments. There is no explicit mechanism to "strike" a brief. Therefore, we deny Respondent's Motion to Strike Petitioner's Response to Respondent's Statement of Exceptions.

Clerical Errors

Throughout the Arbitrator's decision, there are "'s" (apostrophe S-es) without any subject. For example:

> Page 8: Paragraph at top of page (lines 1 and 4);
> Page 9: First line of 2nd full paragraph;
> Page 10: 2nd line of page

We find that, where appropriate, these and similar instances should state "Petitioner's."

Evidentiary Issues

Respondent's Petition for Review includes the issue of "(2) Inclusion of studies not offered into evidence and inconsistent with evidentiary findings at issue." The Arbitrator wrote:

> At the time of Arbitration, the petitioner attempted to enter various studies relating to firefighter exposure and the incidence of prostate cancer. **Petitioner attempted to enter these various studies as his Exhibit #10 and Respondent objected to same, citing hearsay**. The Arbitrator sustained the objection and an offer of proof by Petitioner's counsel was made. The Arbitrator holds that the objection to admission was properly sustained.
>
> Petitioner's counsel, in an attempt to offer a hearsay exception, stated that the studies were a public record. In looking at the studies, the public record exception does not apply. The studies were not authored by any governmental body. The studies are not certified official records from a public office.
>
> In regard to Dr. Orris' testimony, the Arbitrator can consider his opinions regarding the scientific studies he referenced, consistent with Illinois Rules of Evidence 703. Under Rule 703, the mere fact that the witness referenced the studies, does not make the studies admissible. His opinion on those studies is admissible, but the studies are not, unless offered and accepted. The only study offered into evidence without objection was Petitioner's Deposition Exhibit #4, authored by Grace Le Masters. **The rest of the studies were offered as an attachment or were withdrawn. The studies must be offered and not objected to based on hearsay**.

> In regard to Dr. Elterman's testimony, the petitioner cross-examined the doctor with various studies. The studies were never offered into evidence but were rather offered as an attachment. Accordingly, those studies are not admitted into evidence but the opinions of Dr. Elterman regarding same are admissible.

Dec. 21-22 (Emphases added). Respondent argues that, despite the Arbitrator's finding that that only the Le Masters study was admitted into evidence, the Arbitrator improperly relied on the other studies:

> For instance, on page nine of the Arbitrator's opinion, there is a lengthy footnote **citing a study not offered into evidence**. The study was from the National Institute of [sic] for Occupational Safety and Health and Dr. Orris did testify to the conclusion found in same. **The study was merely offered as an attachment to the deposition** transcript. The footnote discusses findings and conclusions that were beyond the scope of Dr. Orris' testimony. Accordingly, that footnote and resulting discussion could not have been relied on by the Arbitrator in his decision. *R-brief at 19 (Emphases added)*.

We disagree with the Arbitrator and Respondent on this issue. In our view, Petitioner's attorney *did* "offer" the studies into evidence at the depositions and Respondent did not make valid hearsay objections. Although there were slight variations, on multiple occasions, Petitioner's attorney offered a study "as an attachment" and Respondent's attorney did not object. On other occasions, Respondent's attorney stated, "The only objection, it will be subject to cross examination" and "Subject to cross-examination, of course." *Px8 at 21, 44*. At one point, Petitioner's attorney offered an exhibit "as an attachment" and Respondent's attorney said, "Feel free." *Rx2 at 44*.

We disagree with the Arbitrator's finding that these studies were only offered as "attachments" and not as evidence. In workers' compensation cases, the depositions taken are *evidence* depositions not discovery depositions. We question what reason a party would have to "offer" a document as an "attachment" if it is not intended to be used as evidence. At each of those times, Respondent's attorney could have either objected based on hearsay or at least clarified for what purpose the studies were being "attached." In our opinion, Petitioner's attorney was not required to say the "magic" words, "I am offering this into evidence." We believe that offering the studies as an "attachment" was clearly intended to have them admitted as evidence. Significantly, neither the Arbitrator nor the parties cite any case law or precedent on this claimed distinction between an "attachment" versus "evidence."

Therefore, we find that all the studies that Petitioner's attorney offered during the depositions should have been admitted because they were not objected to by Respondent. However, we agree with the Arbitrator that the studies in Px10, which had not previously been offered at a deposition, were properly excluded based on Respondent's hearsay objection.

Based on the above, we believe the Arbitrator's citation to the journal article at FN1 on page 9 of the Decision was appropriate.

Exposure

The Arbitrator found "that the preponderance of the testimonial, documentary and expert opinion evidence supports that the petitioner has met his burden of demonstrating exposure to carcinogens under Section 1(d) of the Illinois Occupational Disease Act as a result of his employment with Respondent." *Dec. 26*.

"Exposure" is checked on Respondent's Petition for Review and Respondent argues that the Arbitrator "erred in finding that the Petitioner was last exposed to an occupational disease that arose out of and in the course of employment for the Respondent." *R-brief at 1, 10*. However, Respondent's brief primarily discusses the rebuttable presumption and causation; not exposure. We find the Arbitrator's analysis regarding Petitioner's exposure to carcinogens (*Dec. 22-26*) is hereby affirmed.

Causation - Presumption

We disagree with the Arbitrator's finding that Respondent failed to rebut the presumption in §1(d) of the Occupational Disease ("OD") Act that Petitioner's prostate cancer was causally related to his employment. Addressing a similar provision in the Workers' Compensation ("WC") Act, the Appellate Court has found:

> based on the above legislative history, we find that section 6(f) does not involve a strong rebuttable presumption, requiring clear and convincing evidence. Rather, we conclude that the legislature intended an ordinary rebuttable presumption to apply, simply requiring the employer to offer *some* evidence sufficient to support a finding that something other than claimant's occupation as a firefighter caused his condition.

Johnston v. IWCC, 414 Ill. Dec. 430, 441 (2nd Dist., 2017) (Emphasis in original). The Court continued:

> We address here claimant's assertion that in order to rebut the presumption, the employer had to do more than simply point to other potential causes of his coronary artery disease without first *excluding* occupational exposure as a contributing cause. He cites to case law in support of the proposition that to prove causation, a claimant need only establish his occupational exposure was *a* factor in the resulting condition of ill-being. [Citation omitted.] While it is correct that in order to obtain an award of benefits under the Act, a claimant need only prove an employment risk was *a* cause of his condition of ill-being (*Sisbro, Inc. v. Industrial Comm'n…*), we find this basic proposition of law is not applicable in the context of a section 6(f) presumption. Nothing contained in the legislative debates on House Bill 928 indicates the legislature intended that an employer be required to eliminate any occupational exposure as a possible contributing cause of a claimant's condition in order to successfully rebut the presumption that the disease or condition arose out of his employment. Claimant cites no authority in support of this proposition and we decline to so hold. We note that if the employer is successful in rebutting the section 6(f) presumption, *at that point* the claimant may, if the evidence supports it, assert that his occupational exposure was *a* cause of his condition of ill-being, along the lines of *Sisbro*, thus entitling him to an award of benefits.

Johnston v. IWCC, 414 Ill. Dec. 430, 442-43 (Emphases in original). *See also Simpson v IWCC*, 2017 IL App (3d) 160024WC; 79 N.E.3d 643; 2017 Ill. App. LEXIS 260; 414 Ill. Dec. 8 (2017).

Based on our review and comparison of §1(d) of the OD Act and §6(f) of the WC Act, we find there is no substantive difference regarding the rebuttable presumption between them. Therefore, we find that the Court's rationale in *Johnston* should also apply to the OD Act. Although, pursuant to Supreme Court Rule 23, we are unable to cite to a precedential case on this issue, our review of case law enhances our belief that the Appellate Court would agree with our finding that only *some* evidence is required for Respondent to rebut the presumption in §1(d) of the OD Act.

In the case at bar, we find that Respondent did introduce *some* evidence to rebut the presumption. First, Dr. Elterman opined that Petitioner's prostate cancer was not related to his employment but, rather, he was high risk due to his family history. *Rx2 at 13*. Second, Petitioner's physicians, Dr. Coogan and Dr. Mehta, both signed Duty Status Reports stating that Petitioner's diagnosis of prostate cancer was an "off duty" illness as opposed to an on-duty illness. *Rx3*.

Causation – Medical Evidence

Having found that Respondent successfully rebutted the presumption in §1(d) of the OD Act, the question is whether Petitioner has proven that his occupational exposure was *a* cause of his prostate cancer. After thoroughly reviewing the testimony of Dr. Orris and Dr. Elterman along with the studies in evidence, we summarize our findings as follows:

- Dr. Orris opined that Petitioner's prostate cancer is causally related to his work as a firefighter. He believes the scientific literature supports his position and, although there can be other contributing factors (e.g., Petitioner's family history of prostate cancer), this does not mean that his occupation was not *also a* factor.

- Dr. Elterman opined that Petitioner's cancer was not related to his employment because the literature indicates that he was at a high risk for prostate cancer due to his family history. He believes that it is possible that someone's environment can contribute to the development of prostate cancer, but he does not agree that multiple studies showed increased incidence of prostate cancer in firefighters. He believes more recent studies represent more current data. He opined that "at best" there is a "contradictory picture of relationship between exposure of firefighters and prostate cancer incidence." *Rx2 at 62*. Some studies actually show a decreased (inverse) incidence of prostate cancer. *Id. at 63*.

- The Le Masters meta-study (analysis of various other studies) was done in 2006 and indicated a 1.28 Standardized Incidence Ratio (SIR) of prostate cancer in firefighters versus the general population. However, the Daniels study in 2013 is a much larger study. It also suggests an association between firefighting and prostate cancer incidence (but not mortality) but, it was only 1.03 SIR, which is not statistically significant according to Dr. Elterman. Furthermore, although the SIR increased to 1.45 in subjects between 45 and 59 years old, the study itself indicates that a plausible, alternative explanation is that medical screening (PSA tests) "may be more frequent among firefighters with improved healthcare availability and heightened cancer awareness" than the general population. In other words, the firefighters are simply diagnosed with prostate cancer sooner than the general population due to better access to medical care and diagnostic testing.

In our view, it does not matter how many older, limited-scope studies suggest a correlation between younger firefighters and the incidence of prostate cancer. Relying on these studies would be substituting correlation for causation and no study has proven, to a statistically significant degree of scientific certainty, that any of the chemicals and substances to which Petitioner was exposed as a firefighter actually increase the incidence of prostate cancer. Nor do a large number of studies necessarily equate to valid results because correlation still does not equal causation. Ultimately, we do not find Dr. Orris's causation opinion persuasive on this issue. Instead, we find the opinion of Dr. Elterman most persuasive in this case.

In addition to the above, we find it significant that Petitioner's own treating physicians

affirmatively indicated that Petitioner's prostate cancer was related to "injury/illness off duty." Granted, they may not have been epidemiological experts, but they represent the opinions of Petitioner's treating physicians. Dr. Orris attempted to explain that clinicians have "difficulty…in reading and understanding the weight of evidence within the epidemiologic literature that's looking for causative effects." *Px8 at 31*. However, we do not necessarily agree that treating physicians have difficulty understanding medical studies. Regardless, these are two physicians, in addition to Dr. Elterman, who indicated that Petitioner's cancer was an "off duty" illness.

Although we are reversing the Arbitrator on the issue of causation, we want to specifically address the Arbitrator's citation to *Simpson v. IWCC*, 2017 IL App (3d) 160024WC, ¶55. *Dec. 29*. In finding causation, the Arbitrator cited to the Dissent in that case instead of the majority opinion. Since the majority in *Simpson* reached the opposite conclusion, we strike this paragraph from the decision.

We also disagree with the Arbitrator's disparagement of Dr. Elterman's qualifications, education, training and experience. *Dec. 17-29*. We do not believe these statements are accurate. The Arbitrator wrote, "When confronted with several studies, including his own, which supported an increased incidence of prostate cancer among Chicago firefighters as compared with the general population, he did not answer and did not provide rebuttal. He admitted that he did not know whether firefighters get prostate cancer at a younger age than the general population." *Dec. 29*. First, this was not actually Dr. Elterman's "own" study. It was a study he cited in his "own" report. We find this significant in terms of the implication that he did not know the contents of his "own" study. Second, Dr. Elterman's statement that he did not know whether firefighters get prostate cancer at a younger age than the general population does not reflect negatively on Dr. Elterman. He was simply saying that the apparent results of some studies do not necessarily reflect reality. As discussed above, the incidence among younger firefighters can be explained by the increase in medical access and testing.

Respondent cites the Commission decision of *Ekkert v. Village of Oak Brook,* 16 IWCC 773; 2016 Ill. Wrk. Comp. LEXIS 622, in which the Commission found the claimant firefighter's prostate cancer was not causally related to his employment, and which Respondent claims is almost identical to the facts of the present case. Admittedly, Dr. Orris in the case at bar gave much more persuasive testimony and is better credentialed than the claimant's expert in the *Ekkert* case. However, Dr. Elterman was found to be persuasive in the *Ekkert* case. Although the Commission's decision in *Ekkert* is not precedential, we agree that Dr. Elterman's opinion is persuasive that the current universe of medical studies and literature is insufficient to prove that Petitioner's employment as a firefighter was even *a* contributing factor in his development of prostate cancer. While a causal connection may eventually become more scientifically supported, at this point, it appears to be speculation based on inadequate studies capable of multiple interpretations and an attempt to substitute correlation for causation.

In summary, although Petitioner has proven exposure to certain hazardous substances as a firefighter, we believe he has failed to prove that these exposures were *a* contributing factor in his development of prostate cancer based on the current state of scientific studies and the persuasive opinion of Dr. Elterman.

Based on our reversal of causation, we vacate the Arbitrator's awards of temporary total disability, medical expenses, and permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, dated June 10, 2019, is hereby reversed on the issue of causation and all awards are vacated.

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

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

August 16, 2021 /s/ *Maria E. Portela*

SE/ /s/ *Kathryn A. Doerries*
O: 6/22/21
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DISSENT

While I would concede that it appears Respondent burst the proverbial bubble and successfully rebutted the presumption set forth in §1(d) of the Occupational Diseases Act, given the incredibly low bar set by the appellate court in the case of *Johnston v. Illinois Workers' Compensation Commission*, 414 Ill.Dec. 430 (2nd Dist. 2017) – holding that the employer need only offer *some* evidence sufficient to support a finding that something other than claimant's occupation as a fireman caused his condition, even though that decision considered the rebuttable presumption set forth in §6(f) of the Workers' Compensation Act -- I believe that the preponderance of the credible evidence still ultimately supports Petitioner's claim that he was both exposed to carcinogens as a result of his 29-year history as an active-duty firefighter and that at the very least his occupational exposure was *a* contributing cause of his condition of ill-being pursuant to *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003).

Along these lines, I found the opinion of Dr. Orris to be highly persuasive and much more worthy of reliance than the opinion offered by Respondent's §12 examiner, Dr. Elterman. More to the point, I believe Dr. Elterman was all too willing to minimize and even dismiss the very real occupational risk of cancer, including prostate cancer, occasioned by firefighters in the line of duty to focus exclusively on Petitioner's family history – namely, that his father suffered from the disease. Indeed, while Dr. Orris acknowledged Petitioner had an increased risk of prostate cancer given this history, he logically and rightly posited that Mr. Mangiameli's exposure to carcinogens as a result of his occupation as a firefighter was also a significant factor which served to increase the risk of developing cancer even more, based upon the studies he referenced during the course of his deposition testimony. To say that Petitioner's almost 30 years of active-duty service as a firefighter played no role in his subsequent cancer strains credulity to say the least.

For that reason, I respectfully dissent, and would have affirmed the Arbitrator's decision in its entirety.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0416

MANGIAMELI, THOMAS
Employee/Petitioner

Case# **17WC030825**

VILLAGE OF HOFFMAN ESTATES
Employer/Respondent

On 6/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2512 THE ROMAKER LAW FIRM
PATRICK G SEROWKA
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Thomas Mangiameli
Employee/Petitioner

v.

Village of Hoffman Estates
Employer/Respondent

Case # **17 WC 30825**

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 **Chicago**, on **01/17/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Was Petitioner last exposed to an occupational disease that arose out of employment?
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. X **Evidentiary Findings**

FINDINGS

On **March 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 ***was last exposed to an occupational disease that*** arose out of and in the course of employment for Respondent.

Timely notice of these accidents was given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to this exposure.

In the year preceding the injury, Petitioner earned **$115,662.58**; the average weekly wage was **$2,224.28.**

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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

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

ORDER

TTD

The arbitrator awards TTD at a rate of $1,435.17 for the period of May 17, 2017, through January 30, 2018, a period of 36-6/7 weeks, which totals $52,900.37.

Respondent's Credit for TTD

Respondent is due a credit against its liability for temporary total disability benefits paid totaling $3,029.00.

Medical benefits

Petitioner has agreed to Respondent's credit for medical expenses paid by its group carrier under §8(j)(1) in the amount of $469,385.35 and per the language of §8(j)(1) Respondent will indemnify and hold Petitioner safe and harmless from any and all claims for liability by Blue Cross Blue Shield to the extent of these payments. Otherwise, the arbitrator awards the following medical bills to Petitioner of $179.60 to Swedish Covenant and $499.00 to Dr. Paik of Northwestern United Urology per fee schedule.

Permanent Total Disability

Respondent shall pay Petitioner permanent partial disability benefits of 40% loss of use of the person as a whole (200 weeks) at a rate of **$775.18** per week as provided in §8(d)(2) of the Act.

Penalties

Penalties and fees are denied.

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

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

Signature of Arbitrator

June 9, 2019
Date

JUN 10 2019

FINDINGS OF FACTS

The Petitioner testified that he began working as a firefighter for the Village of Hoffman Estates on August 26, 1988. He testified that he was employed continuously in that capacity until his retirement in July of 2018. As part of his employment, the Petitioner would respond to various emergency calls. The calls included car accidents, medical, and fires.

The Petitioner testified that at the beginning of his career, he was assigned to Station 22 which was the headquarters station. Being at the headquarters did not affect the frequency or type of calls the Petitioner went on. He testified that he would go on whatever call came into his district. The Petitioner did testify that Station 22 responded to a lot of car accidents due to its location near I-90. The station also responded to fire calls in the more depleted areas of the village. The Petitioner testified that he worked at Station 22 for six years. He worked two to three shifts per week and would average five to ten calls per day.

After working at Station 22, the Petitioner testified that he worked at Station 21 for seven to eight years. His weekly call volume was similar to the previous station. The Petitioner testified that he responded to a lot of car accidents at the intersection of Route 72 and Roselle Road. He testified that he would not wear a self-contained breathing apparatus when responding to a car accident unless there was a fire. When responding to an auto accident, the Petitioner might come into contact with radiator fluid, oil, gasoline, and smoke. If there was a car fire, the Petitioner would put on his air mask unless there were injuries on the scene. He would also respond to semi-truck accidents.

After working at Station 22, the Petitioner estimates that he put in at least five years at Stations 23 and 24. The call volume at those stations was about the same as the previous stations.

The Petitioner testified to a Hoffman Estates Fire Department Staff Incident Responses report that detailed his calls from 2005 to 2017. The report identified 1,558 calls during that time period. The report summary did not contain incidents between 1988 and 2004. This report was entered into evidence as Petitioner's Exhibit #2. The Petitioner testified that the list did not include calls of incident types 321, 322, 323, and 324. The Petitioner entered into evidence as Exhibit #3 an incident coding explanation. That coding explanation indicated that call types 321, 322, 323, and 324 were emergency medical service incidents. The Petitioner testified that Petitioner's Exhibit #2 did not reflect any of the four different codes involving car accidents. The Petitioner estimated that he responded to five to fifteen auto accidents per week. He could not remember how many of those accidents resulted in leaking fluids or fumes. If there were fumes, they would blow in the direction of the wind. On cross-examination, the Petitioner admitted that if a car was on fire, he would code it as a fire rather than under the excluded codes. Overall, the Petitioner estimated that he responded to approximately 5,000 additional incidents.

Petitioner's Exhibit #2 details 1,558 incidents between January 3, 2005 and December 31, 2017. During that 12-year period, the Petitioner spent 507.45 total hours responding to calls with an average incident time of 0.32 hours. The Petitioner responded to 143 fires, 29 over pressure/explosions, 9 rescues, 169 hazardous conditions, 271 service calls, 283 good intent calls, 650 false alarms, and 4 severe weather calls. Of the 143 fires, car fires would be included in that number if the Petitioner arrived on the scene and the car was on fire. If the car was not on fire, it would not be a part of the 143 fires.

The Petitioner testified as to the gear he would wear in the performance of his work. His turnout gear consisted of boots, bunker pants, bunker coat, gloves, hood, and a helmet. He also had an air-pack that provided him with fresh air and a mask. The Petitioner testified that as time

went on, his gear improved. If the Petitioner was going into a situation that was an immediate danger to life or health (IDLH) he would mask up. He generally would not mask up for outdoor scenarios or non-structure fires. The Petitioner testified that he was not forbidden from wearing a mask if a "mask up" order was not received. The Petitioner testified that depending on which way the wind was blowing in outdoor fires, he would cough if he caught smoke. For structural fires, the Petitioner testified that he would mask up if there was heavy smoke and heat.

The Petitioner testified that it would typically take fifteen to thirty minutes to fight a fire, depending on the size. He testified that since 1988, building materials have changed, making fires increasingly hotter and faster burning. After a fire is suppressed, the Petitioner testified that he would participate in overhaul. Overhaul consisted of tearing open ceilings and walls to ensure that there was no fire extension or people or animals in the house. The Petitioner testified that at the beginning of his career, overhaul would begin after the structure was ventilated and an all clear was provided. He did not wear a mask then. The Petitioner testified that later when performing turnout, they were required to bring in four gas monitors. The monitors would check for oxygen, carbon monoxide, hydrogen sulfide, and upper and lower explosive limit. Once the monitors were back to normal, they could take off their air-packs. After overhaul, the Petitioner testified that he would proceed with salvage. Salvage involved preserving property.

After the completion of a fire, the Petitioner would get his rig back in service. This involved rolling the hose, putting new hose on the truck, cleaning tools, and refilling air bottles. The Petitioner testified that he would not take a shower or change clothes until the rig was back in service. There would be soot on his neck and coming out of his nose. The Petitioner testified that he never received any medical treatment for respiratory or breathing problems during his career. The Petitioner's gear would also contain soot and residue after a fire. For the first ten

years of the Petitioner's career, he would rinse off his gear with a hose and hang it to dry. The village eventually purchased gear washing machines on or about the year 2000, for two of the stations. If the Petitioner was not at a station that had a gear washing machine, he would rinse off his gear or send it to a station that had a washing machine.

The Petitioner testified that the vehicle engines were run inside the station garage. The doors were typically open but were cracked just enough in the winter to get the exhaust out. Exhaust collection devices were not used until the 1990's. The trucks were idled for no more than five to ten minutes. The Petitioner testified that the firehouse would be staffed with seven or more firefighters per a 24-hour shift. They all slept in a bunk room that had ten beds. The Petitioner's sleep would depend on the number of calls received throughout the night.

The Petitioner testified that his father had prostate cancer. His father was a battalion chief in World War II and later had a career as a tool and dye man. The Petitioner has four other brother and none of them have cancer. This family history is consistent with the history provided to his treating physicians. The Petitioner testified that he worked at his father's tool and dye shop for one summer between junior and senior year of high school. While working at the tool and dye shop, he did not wear any respiratory equipment.

The Petitioner testified that in 2002, at the age of 43, he was diagnosed with an elevated PSA. The elevated PSA was discovered after the Petitioner's yearly village physical. A subsequent biopsy was benign. The Petitioner began to treat with Dr. Paik in 2015 and he was once again diagnosed with an elevated PSA. The Petitioner had an elevated PSA test on November 29, 2016. In January 2017, Dr. Paik sent the Petitioner for further testing. Around the same time, the Petitioner suffered a neck injury during a training exercise on February 28, 2017. The Petitioner was off for three weeks for the neck injury and then worked light duty.

On March 22, 2017, the biopsy results reflected malignancy of the prostate. The Petitioner then went to Dr. Coogan on April 10, 2017 and he recommended a prostatectomy. The Petitioner testified that Dr. Coogan was aware that he was employed as a firefighter. The Petitioner testified that he underwent a prostatectomy and removal of lymph node on May 17, 2017. Thereafter, Dr. Coogan restricted him from work on May 17, 2017. The Petitioner took sick time during this period. Dr. Coogan continued to restrict the Petitioner through August of 2017. The Petitioner was referred to Dr. Mehta for additional treatment on August 9, 2017. Dr. Mehta recommended the Petitioner undergo hormone radiation therapy. The Petitioner underwent radiation therapy on October 2017 through January 2018. Dr. Mehta restricted the Petitioner from work through the end of December 2017. The Petitioner then underwent Cyberknife radiation on December 28 – 29, 2017 and January 3 – 5, 2018 under Dr. Adam Dickler. Thereafter, Dr. Mehta recommend hormone replacement therapy for the next two years. Dr. Coogan continues to perform those hormone injections. Entered into Evidence as Respondent's Exhibit #3 were a series of off work slips. The off-work slips were filled out by the Petitioner's treating physicians, Dr. Coogan and Dr. Mehta. The notes restricted the Petitioner from work beginning on June 22, 2017 and ending with a full duty release on January 30, 2018. On all the off-work slips, the Petitioner's prostate cancer was checked off as being "injury/illness off-duty" as opposed to "injury/illness on-duty." The Petitioner testified that he is to be tested every four months. His cancer is currently in remission. The Petitioner underwent neck surgery in February of 2018. In June of 2018 the Petitioner was released to full duty for his neck. The Petitioner testified that he retired from the fire department on July 16, 2018.

The petitioner's records reflect that he had a high PSA test in 2002 at the age of 42 these would be correct. The January 18, 2017, records of Dr. Paik reflected a history of elevated PSA, a recent rising PSA and referral for a Trans rectal ultrasound and prostate needle biopsy. The

January 18, 2017, PSA test reflects a high PSA result of 11.10. Further, the records of Dr. Paik reflect a February 21, 2002 negative bilateral prostate biopsy. The March 17, 2017, record of Dr Paik states they await results of biopsy performed today. The March 22, 2017, pathology report of the biopsy reflected an adenocarcinomas of the prostate at the following regions: left lateral base Gleason Score 7, mid left lateral Gleason Score 6, Left base Gleason Score 6, Left mid Gleason Score 8, right base Gleason Score 8, right mid Gleason Score 7, right apex Gleason Score 6, right lateral base Gleason Score 7, right lateral mid Gleason Score 7 and right lateral apex Gleason Score 7. (PX 4, pp. 17-18, 13-27). The arbitrator finds 's second choice of physician was Chris Coogan of URO Partners. The April 10, 2017, records of Dr. Coogan reflect a prior history of elevated PSA in 2002, a negative biopsy at that time and a stable condition until the cancer diagnosis by Dr. Paik of 3/17/2017. (This date was mistaken as the biopsy report was not made or reported to Dr. Paik until March 22, 2017). The record of Dr. Coogan listed the areas of adenocarcinoma as reflected on the pathology report including the percentage of tissue invaded. Dr. Coogan discussed treatment options and the petitioner opted for a laparoscopic radical prostatectomy or LARP. The April 19, 2017 records of Dr. Coogan reflect his family history of father having been diagnosed with prostate cancer but dying of something else at 94 years of age. Further, a discussion of surgery including the likelihood that nerves may likely not be able to be sparred due to the high Gleason 8 score bilaterally. (PX 5, pp. 24-27).

On May 17, 2017, he underwent a radical prostatectomy with right lymph node dissection, non-nerve sparring for bilateral Gleason 8 bilaterally. Complications of recurrence, incontinence and erectile dysfunction were discussed. The pathology report reflected Adenocarcinoma, Grade Group 4(Gleason Score 8) involving both lobes and associated with focal extra prostatic extension and vas deferens invasion. Further, invasion of lymph-vascular surgical margin positive for malignancy with tumor involving the right lateral margin, apex and base margins; Stage pT3aN0. Further, the percentage of the prostate involved by tumor was 14/23 blocks involved. (PX 6, pp. 5-11).

On August 9, 2017 Dr. Coogan referred Petitioner to his partner at URO Dr Mehta and he commenced care with Dr. Mehta on that day. Dr. Mehta was concerned about the high PSA values post-operatively and saw enlarged pelvic lymph nodes on CT consistent with lymph node metastasis and he recommended hormone injections to be administered by Dr. Coogan followed

by radiation therapy. (PX 7, pp. 68-71). The records of Dr. Coogan from August 2017 through December 2017 reflect three Lupron injections, erectile dysfunction unresponsive to Cialis, urinary incontinence, urinary tract infection from Foley catheter. (PX 5, pp. 44-51). The records of Dr. Mehta of URO Partners reflect radiation therapy on 10/12/2017 through 12/22/2017 the prostate fossa, peri-prostatic tissues and pelvic lymph nodes. Further, the 12/22/17 Dr. Mehta reflects a referral for Cyberknife boost radiation to the two larger pelvic lymph nodes. (PX 7, pp. 81-95). The records of Radiation Oncologist Chicago/Cyberknife Cancer Institute of Chicago/program of Swedish Covenant reflects a letter to Dr. Mehta recounting the nature of the cancer, his reading of metastatic invasion of the vas deferens and six focal Cyberknife radiation treatments of the lymph node regions of metastasis bilaterally on from 12/28/17 - 1/5/2018. (PX 9) The 4/19/2018, 8/13/2018 and 12/20/18 records of Dr. Coogan reflect Lupron injections and a referral to Dr. Levine for erectile dysfunction pp. (PX 7, pp. 52-53, 57-58, 61-62). On 12/20/2018 Dr. Coogan referred him to his colleague Dr. Levine for penile implantation of a device to treat erectile dysfunction and the procedure is scheduled for February 4, 2019. The 12/21/18 records of Dr. Levine/URO reflect, prior to surgery, great erections but no erectile function since surgery. Further, this record reflects a discussion of treatment option and election of the implantation of the Titan device. (PX 5, pp. 65-66). He is in remission but still under treatment for Cancer with testing every four months, hormone shots [Lupron] from Dr. Coogan and follow up appointments scheduled in April 2019 with Dr.'s Mehta and Coogan. He worked up and through his retirement date in July 2018. (Tr. 82-85).

TESTIMONY OF PETER ORRIS, M.D.

On October 19, 2018 Peter Orris, M.D. Chief of Occupational and Environmental Medicine at the University of Illinois Hospital & Health Sciences System testified for Petitioner. In addition to his post at University of Illinois he teaches internal medicine at Rush, Preventative medicine at Northwestern and Occupational and Environmental Medicine at the University of Illinois Medical Schools. Further, he's Board-Certified in Occupational Medicine, Board-Certified in Preventative Medicine, and he achieved a Masters degree in Public Health from Yale. His CV was offered into evidence. (PX 8, pp. 3-6).

Dr. Orris estimates he has reviewed 50-60 studies assessing the occupational exposures of firefighters to carcinogens. Further, he edited the state of the art reviews of firefighter's health back in 1995 and followed it closely since that time. He drafted a report dated 8.10.2018 upon

the request of 's attorney. In conjunction with the creation of the report he examined Petitioner, took a work and medical history and reviewed various personnel and medical records. These included personnel records reflecting his hire in August of 1988 and a 42 page summary of calls Petitioner attended between 2005 and 2017. Further, he reviewed the medical records of 's cancer diagnosis and treatment including biopsy, PSA testing, records of Dr. Coogan, records of Dr. Mehta and surgical pathology reports. Further, Dr. Orris confirmed the information provided, reviewed and relied upon is the type of information upon which a board-certified occupational physician would normally rely when opining on the issue of causation. (PX 8, pp.7-10).

Dr. Orris recounted that the history provided by Petitioner included reporting to 15-20 calls per week (75% of which were medical as he was cross trained as a medic), 25% structural, car or other types of fires. For the first 15 years of his career his "turn out" gear was simply washed with water. Later, they had more aggressive ways of cleaning the gear because of the continuing presence of poly aromatic hydrocarbons and other carcinogens. Further, he reported that upon returning home from fires he frequently had soot on him and coughed-up soot returning from fires. When he washed himself, he would see soot washing off into the drain. (PX 8, pp.10-11).

The history from Petitioner was that during the fire he would wear his SCBA but when he left the fire or went back to the truck he would take off his SCBA. Dr. Orris indicted this is an area of extended exposure for firefighters. Further, he indicated that he never wore either a half face respirator or the SCBA during the phase of "overhaul". When he would go back in to aerate the fire he would he exposed to the partial paralysis products of the original fire; an area of exposure to carcinogens. (PX 8, pp.11-12). Dr. Orris testified to his familiarity of the firefighters' exposures in the different stages of fire suppression. He highlighted that the "overhaul" process or aeration is a firefighter's primary exposure as they are not wearing respirators/SCBA and most exposed to chlorinated organic compounds, the chlorinated plastics, wood, carbon monoxide and other compounds of that sort. (PX 8, p. 12, 15). Dr. Orris stated typically the overhaul phase is considerably longer than the suppression. (PX 8, p. 13). Dr. Orris recounted the petitioner's history where he was exposed to diesel exhaust during daily vehicle maintenance as there weren't exhaust collection devices for many years until the newly-designed firehouses. He

recounted how Petitioner would smell diesel fumes both in the garage and throughout the firehouse. (PX 8, pp. 14-16).

Dr. Orris is familiar with the studies on chemical exposures present during the off-gassing from overhaul. Of particular interest since the 1980s are the changes in building materials; the introduction and growth of use of chlorinated plastics, polyvinyl chloride and other things of that sort. We are interested in these because of the creation of dioxins when those things are burned as well as polyaromatic hydrocarbons that are generated. Both groups of chemicals are carcinogenic. There have been many studies about the chemicals over a period of years and they all include Benzene. Most include benzo pyrene and a variety of other well-known carcinogenic polyaromatic hydrocarbons. (PX 8, p. 17). The significance of a 15-year history where they only rinsed out their turnout gear in between fires; Dr. Orris indicated that recent publications have found that these byproducts of fires are difficult to wash off; certainly any of a chlorinated organics are hard to wash off. So, firefighters get re-exposed to these chemicals when they touch their turnout gear or at the firehouse. Dr. Orris indicated that the polyaromatic hydrocarbons can be absorbed through the skin in this fashion. (PX 8, pp. 18-19).

Dr. Orris was handed 's exhibit #2 and was offered as an attachment to the transcript. He explained it was a recent study from the National Institute for Occupational Safety and Health which is an agency of the federal government with a special emphasis on firefighter health and safety for the last 20 years.[1] Dr. Orris added that he was regional medical officer for the Midwest for NIOSH in the 1980s and they commenced the study on mortality of Chicago firefighters. This was a study on personal protective equipment and firefighter exposure to chemicals. Dr. Orris opined after reviewing the study that it confirmed his earlier opinions that it's hard to clean this equipment and the residue stays on it [volatile compounds and polycyclic aromatic

[1] At page 1, the abstract states firefighters skin can be exposed to chemicals via permeation of combustion byproducts through or around PPE or from cross-transfer of contaminants on PPE to skin and from breathing in evaporated polycyclic aromatic hydrocarbons and volatile organic hydrocarbons following a response. This was a study conducted at the University of Illinois. Further, the first paragraph of the introduction cited the conclusions of the 2nd *Daniels* [relied on by Dr. Elterman] that increased mortality and incidence risk for cancers and an elevated risk of many cancer, including prostate, was found among young firefighters. At page 802 it commented on materials in modern buildings are synthetic and include PAH and VOC. Further, these multiple contaminants are either known or probable carcinogens that can be transferred to living spaces of firefighters and absorbed dermally due from the hood, turnout jacket, trousers from gear to skin where studies found high amounts of Benzene and PAH on their skin[hands/neck]. Pp. 802, 807-808. These exposures were increased by bi-annual gear cleaning and the rare practice of field decontamination where median levels of PAH are higher with successive uses in fires. P. 806 Pet. Dep. Ex. 2, "*Contamination of firefighter personal protective equipment [PPE] and skin and the effectiveness of decontamination procedures*" Fent, Journal of Occupational and Environmental Hygiene (2017).

hydrocarbons] and the study quantified the amount of buildup. The arbitrator finds the conclusions of the study support Dr. Orris' testimony and align with 's testimony on dermal exposure, i.e., increased levels of dermal exposure of PAH and VOC's due to infrequent cleaning of gear where median levels of carcinogens increase with successive uses in fires. (PX 8, pp. 19-20).

Dr. Orris explained exposure to diesel exhaust is significant; as it is a well-known carcinogen. (PX 8, p. 21). Dr. Orris testified that, what we know across the board: firefighters are exposed regularly to a variety of carcinogens, all of which have not been yet identified. Dr. Orris' understanding of Petitioner's medical history is that his prostate cancer it probably originally manifested someone earlier than it was finally diagnosed. He noted the rise in PSA in 2003, while he was in his forties. Now that PSA biopsy was negative meaning that either it did not indicate prostate cancer or more specifically at their biopsy missed the cancer, it was small and within the prostate itself, so they adopted an approach to watch and wait and follow with PSA testing. When it began to rise some 15 years later implying that it was quite slow growing and then they went back and made the diagnosis when he was in his fifties. (PX 8, pp. 21-23).

Dr. Orris agreed that 's elevated PSA in his forties has some relationship with his occupational exposure. He explained the literature reflected firefighters will develop prostate cancer at an earlier age than the general population. The median age for prostate cancer in the United States population is about 70 or 71 years of age. So, the medical literature reflects firefighters develop prostate cancer at an earlier age and this is relevant to the petitioner because getting an elevated PSA in his forties is quite an early age. (PX 8, p. 23). Dr. Orris opined that 's medical history of earlier expression of cancer is consistent with the medical literature of firefighters having an earlier date of manifestation. (PX 8, p. 29). Dr. Orris explained that family history probably doubles his risk of prostate cancer but that family history only accounts for about 10% of all prostate cancer one way or the other. These two risk factors they will interact to increase the risk further. Dr. Orris testified that Petitioner had increased exposure to carcinogens as a result of his occupation as a firefighter. (PX 8, pp. 23-24).

Dr. Orris opined that firefighters have greater occupational exposure to carcinogens than a member of the general public and that is a function of their occupation. Dr. Orris testified that the petitioner's occupation as a firefighter over this period of time was the cause of his prostate cancer and the lymphatic metastasis. (PX 8, pp. 25-26). Further, Dr. Orris opined that

Petitioner's occupation as a firefighter for Respondent was a causative factor in the need for subsequent treatment to his prostate and lymph nodes. He opined that the treatment he had reviewed was reasonable and necessary as appropriate. There is a causal connection between his occupational exposure and this future need for medical treatment. Further, metastasis into lymph nodes increased the necessity for and risk of further medical treatment due to a significant possibility that what there were other metastasis at the same time (PX 8, pp. 26-28).

Dr. Orris explained that he did review the opinions of Dr. Lev Elterman. Dr. Orris disagreed that the available literature "paint, at best, a contradictory picture as to whether or not firefighters' exposures can contribute to cancer." Dr. Orris indicated that clinicians have difficulty understanding the weight of evidence within the epidemiologic literature that's looking for causative effects. Dr. Orris opined the literature on firefighter with respect to prostate cancer is surprisingly consistent. That doesn't mean there weren't studies that didn't see the effect. But on the weight of the evidence basis, the literature and utilizing Hill's postulate work on inferring causation, the literature with prostate cancer is surprisingly strong. Further, that prostate cancer really jumps out at you in so many of these studies. Dr. Orris indicated there is real variability and the percentage of statistical increase over the general population sometimes it's 20% others will show 200% to 300% increase depending on where they were done and how they were done. (PX 8, pp. 30-32).

Dr. Orris clarified that he is considered an epidemiologist; that his training as an occupational and environmental medicine and preventive medicine includes environmental toxicology as well as epidemiology in assessing causative factors from the literature. He's also been teaching in these specialties for the last 40 years. He discussed his experience and approach in evaluating individual studies that identify association. Based on criteria of toxicology and environmental medicine, a 20% increase of incidence of cancer over the general population is a real finding; it means that the probability that the result could be caused by chance would be less than one in twenty. He finds an [causative]opinion based on this [probability] to be conservative. (PX 8, pp. 33-35). Further, he opined the results of the studies he has reviewed which studied cohorts of firefighters and the incidence of prostate cancer throughout the world have been both consistent and statistically significant. (PX 8, p. 38).

The mistake that clinicians often make in [misinterpreting] this finding as not being statistically significant is due to the focus of their training being diagnosis and treatment and they "fall down" on questions of causative factors. (PX 8, pp. 35-36). He described the difference in approach between an epidemiologist/occupational medicine doctor and a clinician like Dr. Elterman as the job of an epidemiologist/occupational medicine is to identify risk factors in the environment, so they can intervene and change in a preventative way. Where a clinician's primary orientation, appropriately so, is to diagnose the disease and propose treatment. (PX 8, p. 39). Dr Orris reiterated his disagreement with Dr. Elterman' s opinion that Petitioner's occupational exposure was not a factor in his cancer. Dr. Orris was asked about the study cited by Dr. Elterman in support of his opinion "Mortality and Cancer incidence in a pooled cohort of US Firefighters from San Francisco, Chicago & Philadelphia" by Robert *Danielss*; marked and identified as 's dep. Exh. 3.[2] He is familiar with that study based upon the research in Chicago which Dr Orris put together. Dr. Orris opined the study concluded excess bladder and prostate cancer incidence was found among firefighters less than 65 years of age limited to firefighters ages 45-59. Further, that this consistent, as he said before, with other observations and studies; such as *Pukkala,* the one from Scandinavia. (PX 8, pp. 40-42).

He specifically referenced a discussion of increased prostate cancer found in the *Daniels* study in its reference to the *LeMaster's* study. marked the *LeMaster's* study as 's exhibit #4.[3] (PX 8, pp. 42-43). Dr. Orris opined *LeMaster's* demonstrated a probable association between firefighter's exposures and non-Hodgkin's lymphoma, prostate and testicular cancer. (PX 8, pp. 43-44).

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[2] excess cancers of prostate & lung in Chicago Ff & san fran FF & Signidficant age at risk diff in SIR were evidence for prostate cancers ages 45-59. p. 392. study conc early onset of these cacners suggest an association w/ Firefighting. Further, with few exceptions, results consistent with *Lemaster's* study Our findings are consistent with previous studies and strengthen evidence of a relation between firefighters occupational exposure and cancer. P. 395 Pet. Dep. Exh. 3, "*Mortality and cancer incidence in a pooled cohort of US Firefighters from San Francisco,Chicago and Philadelphia"Danielss* RD, *Occup. Environ. Med.* (2014).

[3] A probable association with Non-Hodgkin's lymphoma, prostate, and testicular cancer was demonstrated. Incident study showed significant meta sir for cancers of the stomach prostate 1.29 semicolon reflecting a 29% increase of incidence of prostate cancers of firefighters as compared with members of the general population.- a 95% confidence interval of an increased incidence of prostate cancer of firefighters ranging from 15% more to 43% higher incidence than the general population P. 1192, 1198. The study noted that all the individual studies lemasters had reviewed on incidence of prostate cancer showed significant Elevate elevations of standard incidence ratios among firefighters and all individual studies showed excess standard incidence ratio values for prostate cancer.p. 1198 Pet. Dep. Exh. 4, *"Cancer Risk Among Firefighers: A Review and Meta-analysis of 32 studies"* LeMasters GK et al., "*Journal of Environmental Medicine*". (2006).

Evidence Deposition of Respondent's Section 12 Examiner Lev Elterman, M.D.

On November 12, 2008 the Respondent put forth the testimony of its Section 12 examiner, Lev Elterman, M.D. Dr. Elterman is a board-certified practicing urologist in the State of Illinois. He provided a brief history of his educational background and responded offered into evidence the CV of the doctor. He diagnoses and treats patients for prostate cancer, approximately 10 in a given week. On December 9, 2017, he did examine the petitioner for purposes of his testimony but did not have an independent recollection and relied on his notes. Respondent's exhibit number two is the letter summarizing Dr. Elterman's encounter with Petitioner. (RX 2, pp. 4-8).

At the time of his examination, he reviewed the medical records of Rush University, notes of doctor Coogan's office and various laboratory results. Further, he indicated that he took a medical history. He indicated that Petitioner was diagnosed with an elevated PSA in 2002, and he had a negative prostate biopsy at that time. Subsequently, his PSA rose in January of 2017, and the biopsy was performed in March of 2017. It showed presence of adenocarcinoma of the prostate; Gleason score 8 bilaterally and he then had a prostatectomy in May of 2017. Further, he indicated that the PSA following surgery was elevated and rising; the CT scan showed small pelvic lymph node. For that he was started on Casodex, Lupron and was recommended to start radiation. (RX 2, pp. 8-9).

He took as work history was that he was a "firefighter." When asked about the significance of his employment Dr. Elterman indicated that "his exposures to fires were variable and vary with the seasons." But other than that, I do not know." (RX 2, p.10.)

Dr. Elterman indicated that he did not know if diabetes or obesity were risk factors for prostate cancer. (RX 2, pp.10-11) He indicated that 's father's diagnosis of prostate cancer was significant. The significance is that it is a risk factor for the development of prostate cancer. Further, he indicated family history and age place someone at higher risk for prostate cancer. (RX 2, pp. 11-12)

Dr. Elterman stated that Petitioner's prostate cancer was not related to his employment as a firefighter. His basis for this opinion what is the review of literature and the fact that he was high risk for prostate cancer due to his family history. Dr. Elterman identified Respondent's exhibit 3. He indicated that it was a study that he relied upon informing his opinion on causal connection. He indicated that he is familiar with it and he has reviewed it before. When asked

about its significance with regard to the finding of higher incidence of prostate cancer in firefighters as compared to the general public; he indicated in the main conclusion and he was looking at table listing the standardized incidence ratio and that there was no statistically significant increase in prostate cancer in firefighters. (RX 2, pp. 13-14). He indicated the incidence ratio was 1.03 and the 95% confidence interval range between .98 and 1.09. This was not statistically significant. He explained the standardized incidence ratio means how more likely it is that a certain population at risk will develop certain conditions compared to the general population; that 1 is equal to the general population and 1.03 is 3% over and expected. (RX 2, pp.14-15).

Dr. Elterman was handed Respondent's exhibit number 4. He indicated that he was familiar with the study and that he relied on this study as the basis for his opinion on causal connection. (RX 2, 16). Dr. Elterman explained that the purpose of the study was to look at the firefighters' exposure relationship and the risk of death from prostate cancer. (RX 2, pp.16-17). Petitioner's counsel objected on the basis of relevancy and motion to strike any testimony relying on this study is not relevant as the relevant issue is incidence [cancer] and causation and not mortality and for those reasons the study's conclusions are not relevant to the inquiry in question. (RX 2, pp.17).

The doctor said that the study was also about incidence and that the standard incidence ratio is 1.02. Petitioner's counsel restated his relevancy objection and motion to strike "explaining the discussion section indicates that the purpose of the study is to derive exposure estimates suitable for later use and it is not a study of incidence of cancer as in the first [*Daniels]* study." (RX 2, pp.18). The doctor testified that the study found no statistically significant relationship. (RX 2, pp. 18-19)

The Respondent offered the doctor his exhibit number 5. The doctor indicated that he was familiar with his study and that he relied on it in the formation of his causation opinion. The doctor opined that the significance of this article with respect to incidence of prostate cancer in sons that have a father with prostate cancer showed a relative risk of 2.12; meaning that if a person had father with prostate cancer they're twice as likely to develop prostate cancer than an average man. (RX 2, pp.18-19). The doctor testified that based upon the available literature taken as a whole it paints, at best, an inconclusive relationship between firefighting and the development of prostate cancer (RX 2, p.21). Dr. Elterman agreed that firefighters are exposed

to carcinogens but that he does not know what types of carcinogens to which Petitioner was exposed. Dr. Elterman felt that the care was reasonable and that three years of care should be followed up with a PSA test. (RX 2, pp.22).

Dr. Elterman agreed that 99% of his time is in clinic; treatment of urological problems. He is not board-certified in toxicology, he has never held a job in Occupational Medicine, he has never had an academic post an occupational medicine, he is not board certified in public health, he has never held a job in public health, he has never held an academic post in public health, he is not board-certified in preventative medicine, he is not board-certified in Industrial Hygiene, he never had a job working in industrial hygiene, he is not board-certified in epidemiology and he agreed he has never participated in or conducted a research study on the incidence of cancer in firefighters. (RX 2, pp.25-27). He testified that it was correct that in 2015, 70% to 80% of his medico-legal work for the defense and that since that time the amount done for the defense has increased. (RX 2, pp.27). He would agree that research can develop over time on the issue of occupational exposures and the incidence of cancer; he agreed that if new research were to come out and change the balance of information that it would have an effect on the opinions he said it today. He agreed that he does not study the environmental risks of population cohorts for cancer incidence as his chief occupation. His focus is on treating patients with your urological disorders. (RX 2, pp.27-28).

He agreed that if someone came to him diagnosed with prostate cancer that it would not provide them any benefit for him to tell them that they should have had healthier parents. Or if that same patient came to him saying that they've been working at a benzene factory he agreed it would not do them any good for the doctor to tell them that they should never have worked in the benzene factory in the first place. He agreed that someone who works as an epidemiologist would usually do more population studies in the course of their work than a clinician. He did not know the median age for Caucasian men who develop prostate cancer in the United States. When suggested that it was somewhere in their early 70's; he commented that seemed plausible. (RX 2, pp.28-29). He agreed that how a person develops prostate cancer can be influenced by many factors. (RX 2, p. 31). He did not know the typical age of onset of prostate cancer for the sons of fathers who were positive for prostate cancer. (RX 2, pp. 31). Further, he agreed that there's no test which can discern the cause of an individual's prostate cancer diagnosis. He did think it's

possible that a person's environment can contribute to the development of prostate cancer. (RX 2, pp. 31-32).

He was unaware of any test that can discern a percentage of contribution from different sources that culminated in the condition of prostate cancer. (RX 2, pp. 33). Further, he agreed that just because a person's family history of cancer can contribute to cancer; it does not negate the other causes of cancer (RX 2, pp. 33). Stated differently, he agreed there can be more than one factor which can contribute to the development of prostate cancer. (RX 2, pp. 33-34).

He was asked if he would agree that someone manifesting prostate cancer at the age of 56 is substantially sooner than the median age of a prostate cancer diagnosis. He explained, "I do not remember the median age of prostate cancer diagnosis, so I cannot answer this question. It is not relevant to my daily practice." (RX 2, p. 34)

When asked about the research which reflected that firefighters experience a higher incidence of prostate cancer at an earlier age than a member of the general public he replied, "He did not know the answer to this question." (RX 2, p. 35). He was asked "so you're not aware of whether or not firefighters get prostate cancer at a younger age than the general population?" He replied, "I don't know." Offered exhibit number 1, Petitioner's counsel asked the doctor to review the study. Petitioner's counsel indicated that the article reflects that in five different countries over a period of 45 years they have determined that firefighters have an earlier expression of prostate cancer than the general public. The doctor was asked whether or not he was familiar with this study and the doctor explained "that he does not recollect the findings." (RX 2, pp. 34-36).

Petitioner's deposition exhibit #1 "Cancer Incidence among Firefighters: 45 years of follow-up in five Nordic Countries," lead-authored by *Pukkala,* demonstrated a statistically significantly excess of prostate cancer in firefighters ages 30-49. An SIR (standardized incidence ratio) of 2.59 with a confidence interval range of 1.34 to 4.52; this ratio reflects a range of 34% to 452% higher incidence than the general population. Further, the cohort included 16,422 fire fighters, from five separate countries over a period of 45 years. (PX 14, pp. 2- 8.) Dr. Elterman was asked twice whether the conclusions of a study that found of those diagnosed with prostate cancer; only 8% of them had a brother or father with prostate cancer, "were those findings consistent with the literature on the subject?". Dr. Elterman indicated that he didn't understand the question and after repeat questioning he replied, "I don't know the answer to this

question." He was asked the same question stating if 10% of those diagnosed with prostate cancer had that family history, were those findings consistent with the literature on the subject? He replied that "he didn't know." (RX 2, pp. 37-38)

He admitted that he is not familiar with the types of chemicals firefighters are exposed on the course of firefighting but agreed soot, benzene and arsenic are carcinogens. He didn't know if benzo pyrene or diesel exhaust were carcinogens. Further, he didn't know if firefighters are exposed to arsenic, benzene or arsenic. He did agree that if fire fighters were exposed to these substances they would be part of their occupational exposure and that over his 29-year career it is "likely" that he would be exposed to these things. (RX 2, pp. 39-40). He was not familiar with the chemical composition of fires. He was not familiar with either the studies on fire fighter exposure and bladder cancer, not familiar with studies on dermal exposure to carcinogens and incidence of cancer and not familiar with the studies linking disruption of circadian rhythms in shift work and increased risk of cancer. Petitioner offered as Exhibit #2 a study on sleep loss and disruption of circadian rhythm. (RX 2, pp. 40, 42-43).

Consequently, he had no opinion on whether or not a buildup of chemicals on a firefighter's gear due to insufficient washing could be absorbed by the firefighter and contribute to cancer risk. (RX 2, pp. 42-43). He agreed that he cited the two *Daniels* studies in his report. He was handed the LeMaster's Study it's a meta-analysis of 32 different studies from around the country of firefighters and cancer incidence among those populations. When asked if he was familiar with this study he commented he can't answer the specifics about the study. Petitioner's counsel stated that the study concluded that it was more likely than not that there was an increased risk of prostate cancer related to occupational exposures as a firefighter. Dr. Elterman was asked if the studies' conclusions were consistent with his understanding of the literature. The doctor did not answer. Petitioner's counsel reframed the question and further indicated that the last sentence of the summary italicized stated "that a probable association with non-Hodgkin's lymphoma, prostate and testicular cancer was demonstrated [with fire fighter's exposure]." Further, at page 1198 in the first paragraph it states a summary risk estimate of 1.28 so a 28% higher risk and the general public with respect to the incidence of prostate cancer. The doctor was asked if this finding is consistent with his understanding of literature. The doctor did not answer. The doctor was asked again if the conclusions of this study that there is an increased

risk of prostate cancer among firefighters are consistent with his understanding of the literature, yes or no. He replied "no." (RX 2, pp. 45-46).

The doctor was reminded that it was a meta-analysis of 32 prior studies and was then asked if the repeated demonstration of a higher incidence of prostate cancer in firefighters in these multiple studies would imply a higher degree of reliability in that conclusion. The doctor replied that the study was published in 2006, and that the studies referenced were later and represent more current data. Petitioner's counsel motioned to strike the answer as not responsive. Petitioner's counsel restated this question and Dr. Elterman replied that he disagreed that it would be more reliable, and he thinks that it is an old study. (RX 2, pp. 47-48).

Petitioner's counsel quoted from the *Daniels* study cited by Dr. Elterman, RX 3. Counsel cited that in that *Daniels* study, in the introduction, the latter half of the first paragraph discussed the recent meta-analysis of 32 studies and cites the *Lemaster's* study (citation #14 of *Daniels* study) that concluded a relationship between a firefighter's occupational exposure and increased incidence of cancer. Counsel asked, "was he not aware of the reference to the *LeMaster's* study in his *Daniels* study." He replied that he may have probably read it but was unable to conclusively testify on the relevance of the study. (RX 2, pp. 48-49). The doctor averred that 46 studies were referenced in *Daniels* and he wasn't prepared. The doctor was reminded that the *Lemaster's* study was the first study referenced in RX #3 and he asserted he had read the *Daniels* study. He was asked if it would surprise him if *Daniels* concluded its findings were consistent with the findings of the *LeMaster's* study on the issue of prostate cancer. (RX 2, pp. 49-50). In the first paragraph of the first page of the *Daniels* study the introduction makes reference to the meta-analysis of 32 studies (*LeMaster's)* and the (IARC) study of 42 studies which both show either significant excess risk or significant summary risks for prostate cancer among firefighters. (RX 2, p. 50; Resp. Dep. Ex. 3).

Dr. Elterman denied these findings but counsel directed the doctor to the authors conclusion in the *Daniels* study at page 395 under discussion, the second half of the second paragraph, which states, "with few exceptions, our results are consistent with those previously reported and similar to the SREs presented in the meta-analysis by *LeMasters*". (RX 2, pp. 50-51). Dr. Elterman read into the record portions of the study unrelated to prostate cancer and

asserted the study does not address prostate cancer. Petitioner's counsel directed him to last paragraph of that same page,

> "It states excess bladder and prostate cancer incidence was found among firefighters less than 65 years of age. Wouldn't you agree that would be consistent with a connection between the petitioner's prostate cancer and his exposure as a firefighter for 29 years? You agree it's stated there, right, doctor? Dr. Elterman replied "It's stated there".
>
> "Moving on. It also states, interestingly, the prostate cancer excess was limited to ages between 45 and 59 years which was also consistent with the recent observations in the Nordic firefighters. You'd agree that's there as well, right? Dr. Elterman replied, "That's stated there, yes."
>
> "It actually refers to the Pukkala study that I brought up earlier. So those are all things that tend to show a connection, do they not, doctor? And this is a study you quoted, doctor? Dr. Elterman replied "Yes". (RX 2, pp. 51-53).

The doctor was directed to Petitioner's deposition exhibit #4, the WHO study on the International Agency Research on Cancer which was the second quoted study in the *Daniels* where it reviewed 42 more studies and they reported significant summary risks for prostatic and testicular cancers in firefighters (30% elevated risk of prostate cancer) you'd agree that this conclusion appears to support a connection between prostate cancer and exposure to firefighters is that fair to say doctor? The doctor equivocated, when asked a similar question he replied that the second *Daniels* study with Chicago fire fighters was more applicable to causation than one based on Nordic studies. (RX 2, pp. 52-56). Dr Elterman was directed to page 392 of the *Daniels* study under the section titled quote sensitivity analysis. This section said it found excess cancer the cancers of the prostate in Chicago firefighters, "wouldn't he agree that this study supports a causal connection between Petitioner's prostate cancer and his exposure as a firefighter?" (RX 2, pp. 57-58). The doctor characterized the part as "mortality, excess cancers in San Francisco and lung in Chicago." Counsel completed the sentence where it states, "and excess cancers of the prostate and lung in Chicago." He replied that it was for mortality. (RX 2, pp.58-60).

Petitioner's counsel then directed the doctor's attention to the last paragraph of page 395 and asked "is it fair to say that the first sentence of this paragraph reflects the study found excess bladder and prostate cancer incidence found among firefighters less than 65 years of age?" When the doctor was asked whether these findings are consistent with the literature that

indicates a causal connection to occupational exposure and the incidence of prostate cancer in firefighters, Dr. Elterman maintained that the data and the actual study did not show an excess. (RX 2, p. 60). The doctor agreed that the prostate is part of the genito-urinary tract. His attention was directed to the introduction of the on the first page of the *Daniels* study which states that some studies have found excess cancers of the brain, digestive tract and genitourinary tract. Dr. Elterman was asked to confirm that it was fair to say that those statements are reflected in the study. He did not answer. Again, he was asked "wasn't it true that at that part of the study they reference four studies that support a connection between firefighter exposure and cancer of the genito-urinary tract?" Dr. Elterman conceded that it was true. (RX 2, pp. 60-62).

Counting the number studies analyzed in both *Lemaster's* and *World Health Organization* 16 and 32 studies respectively would total 48 studies. The doctor was asked "whether that repeated demonstration of higher incidence of prostate cancer in firefighters due to their occupational exposure in 48 studies imparts a higher degree of credibility to the opinion that Petitioner's cancer is causally related to his 29 years of exposure as a firefighter?" Dr. Elterman disagreed and maintained that the data paints, at best, a contradictory picture. (RX 2, p. 62). The doctor was asked a similar question and he maintained that the studies he cited demonstrated an inverse exposure dose relationship. When reminded that the study he actually quoted found an excess incidence of prostate cancer in Chicago firefighters, Dr. Elterman responded that it said mortality and that he would have to review it further. When directed to page 392 of the study the doctor ultimate ultimately agreed that the study reflected significant at-risk differences and standardized incident ratios were evident for prostate and bladder cancers. Further, it states prostate cancer was limited to ages 45 to 59 years of age. Further, he was reminded that Petitioner was 58 years of age when he was diagnosed with prostate cancer. He agreed further that at the age of 58 would be within that subgroup cited in the study. (RX 2, pp. 63-64).

Stipulations of the Parties

The petitioner claims that on March 22, 2017, he sustained accidental injuries or was last exposed to an occupational disease arising out of the employment with Respondent. The Respondent stipulated to employment and notice of the condition on April 10, 2017. The Respondent disputed that the petitioner sustained injuries or was last exposed to an occupational

disease that arose out of and in the course of the employment on March 22, 2017. Further, the parties agreed to the petitioner's annual earnings of $115,662.58, the average weekly wage of $2,224.28, and that he was 57 years of age with no dependent children. The petitioner alleges that the Respondent is liable for unpaid medical bills of $469,671.94. The Respondent alleges that these bills were paid pursuant to the employer's group health insurance carrier and can therefore issue a hold harmless agreement on any sums paid by the group health carrier. (Tr., pp. 4-6; Arb. Ex 1)

The petitioner claims TTD from May 17, 2017, through January 30, 2018, a period of 36 6/7 weeks. The Responded disputes this and claims that the petitioner continued to receive sick pay; Respondent clarified that Petitioner received sick pay exceeding the sum owed for TTD, for which they demand a §8(j) credit. However, Respondent agreed that the medical records reflect that Petitioner was disabled for the period claimed. The petitioner disputes the §8(j) credit and demands strict proof. The nature and extent of the injury is at issue and a penalties petition was filed. (Tr., pp. 10-12; Arb. Ex 1).

CONCLUSIONS OF LAW

Respondent's Objection to qualifications Peter Orris, M.D.

Respondent objected at trial to the qualifications of Petitioner's section 12 examiner, Dr. Peter Orris, stating that his medical specialty would not qualify him to act as an expert in this matter. (TA 140). It is noteworthy that the evidence deposition was taken by agreement of the parties and no such objection was made at the evidence deposition. Based on the above, the arbitrator finds that Respondent's objection to the admission of the opinions of Peter Orris, M.D., is overruled.

OFFER OF PROOF

At the time of Arbitration, the petitioner attempted to enter various studies relating to firefighter exposure and the incidence of prostate cancer. Petitioner attempted to enter these various studies as his Exhibit #10 and Respondent objected to same, citing hearsay. The

Arbitrator sustained the objection and an offer of proof by Petitioner's counsel was made. The Arbitrator holds that the objection to admission was properly sustained.

Petitioner's counsel, in an attempt to offer a hearsay exception, stated that the studies were a public record. In looking at the studies, the public record exception does not apply. The studies were not authored by any governmental body. The studies are not certified official records from a public office.

In regard to Dr. Orris' testimony, the Arbitrator can consider his opinions regarding the scientific studies he referenced, consistent with Illinois Rules of Evidence 703. Under Rule 703, the mere fact that the witness referenced the studies, does not make the studies admissible. **His opinion on those studies is admissible, but the studies are not, unless offered and accepted.** The only study offered into evidence without objection was 's Deposition Exhibit #4, authored by Grace LeMasters. The rest of the studies were offered as an attachment or were withdrawn. The studies must be offered and not objected to based on hearsay.

In regard to Dr. Etlerman's testimony, the petitioner cross-examined the doctor with various studies. The studies were never offered into evidence but were rather offered as an attachment. Accordingly, those studies are not admitted into evidence but the opinions of Dr. Elterman regarding same are admissible.

On the issue of whether was exposed to an occupational disease which arose out of and in the course of employment, "C", the Arbitrator holds the following:

It is not the law in Illinois that Petitioner must prove amount, time or duration of exposure to sustain his burden of proof by the preponderance or greater weight of the evidence. The relevant portion of the Section 1(d) of the Illinois Occupational Diseases Act states:

> "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 is employed in an occupation in which the hazard of the disease exists.

820 ILCS 310/1(d) (January 1, 2014)."

A plain construction of Section 1(d) of the Illinois Occupational Diseases Act indicates that the petitioner shall be conclusively deemed to have been exposed to carcinogens in the course of his employment if it is a hazard of his employment as a Firefighter/EMT for Respondent.

Further, this section was discussed in *Freeman United Coal Mining Co. v. Industrial Commission, where* the Supreme Court held that proof of a hazardous exposure is "conclusively established" and not subject to challenge by the employer when the worker proves employment in an occupation in which the hazard exists. The *Freeman* court held that a worker is **not required to provide any proof of the amount, time or duration of exposure.** *Freeman United Coal Mining Co. v. Industrial Commission,*188 Ill.2d 243(1999). The court made clear the employee does not have to identify the particular exposure to conclusively prove hazardous exposure.

Dr. Orris identified several carcinogens to which fire fighters are exposed both dermally and through their respiratory system and correlated these exposures with specific aspects of firefighter's duties. The basis was his review of specific studies, a multi-decade review of studies and his amassed experience over the course of his work in occupational medicine, public health and epidemiology. Further, the studies offered and upon which he relied defined the toxins/substances as carcinogens.

The Arbitrator finds the testimony of Dr. Orris on both the presence of and exposure to toxic and carcinogenic substances by Petitioner in the usual course of his duties as a firefighter/paramedic for Respondent from 1988 through 2017, credible and persuasive.

The Arbitrator does not find the opinions of Dr. Elterman to be credible as lacking both general knowledge of a firefighter's occupational exposure or any specific knowledge of the petitioner's occupational exposure.

Dr. Elterman did not have knowledge of and was unable to testify about the specific call history of the petitioner over the course of his career. Further, he did not have knowledge of and was unable to testify to the different types or vectors of exposures to which firefighters are commonly exposed. Further, Dr. Elterman did not have knowledge of the common chemical

exposures of firefighters nor did he have any knowledge on the chemical composition of fire or smoke.

The Arbitrator finds that the testimony of Peter Orris, M.D. supports that the hazard of the disease of prostate cancer exists in the petitioner's occupation as a Firefighter/EMT for Respondent.

The Arbitrator finds that a preponderance of the testimonial, documentary and expert opinion evidence supports the petitioner's exposure to carcinogens and toxic exposure in the usual course of his duties as a firefighter/paramedic for Respondent from 1988 through 2017.

The Illinois Appellate Court for the First District in *Omron Electronics* found a claimant's death related to his occupational exposure to meningitis while traveling for work to San Paolo, Brazil. The Court found the case compensable despite the failure to put forth any evidence that the employee was exposed to a specific carrier of meningitis while in San Paolo. *Omron Electronics v. IWCC, et al.*, No. 1-13-0766WC, 2014 IL App. (1st) WL 130766WC (November 14, 2014).

In that case, the employee's medical expert cited articles in support of his testimony that international travel increases the risk for contracting meningitis and that San Paolo was well-known in the medical literature, as well as among infectious disease specialists, as an area where there is an increased prevalence of meningitis (2 to 4 times higher than in U.S.). *Id.* at ¶16. In the present matter, Dr. Orris cited both specific studies and general knowledge of studies which supports the existence of the hazard of carcinogens and toxic exposure in firefighting and actual exposure to in the usual course of 's duties as a firefighter/paramedic for Respondent from 1988 through 2017.

In *Omron Electronics,* the medical experts agreed that meningitis could be transmitted through airborne respiratory droplets. Although most carriers do not develop the disease, one exposure was sufficient to transmit meningitis. The Court found that the employee was in contact with numerous people during his trip to Brazil and that any one of them may be infected with meningitis. *Id. at* ¶41. In this matter, Dr. Orris testified credibly about the exposure vectors as a fire fighter, identified specific chemicals/carcinogens to which fire fighters are exposed and had both an oral history and documentary history of 's occupational exposure.

In *H&H Plumbing v. Industrial Comm'n.*, the main issue was whether exposure to asbestos could be inferred from testimony of claimant's co-workers [as career pipefitters] who testified to the appearance of the gaskets, blankets and their role in insulating boilers as a fireproof material on the issue of whether they were made of asbestos. In *H&H*, the claimant failed to introduce an expert opinion in support of exposure and the claimant's medical records did not reflect a history of occupational exposure to asbestos.

The Appellate Court found that the Commission could reasonably infer, from the testimony of co-workers, the fact that these items contained asbestos and the fact of claimant's occupational exposure in the course of his employment. *H&H Plumbing v. Industrial Comm'n,*170 Ill.App.3d 706,525 N.E.2d 155, 160 (1988). Similarly, in the instant matter, the proof of exposure that can be inferred from the testimony is corroborated and supported scientifically by the expert testimony of Dr. Orris.

In *Freeman United Coal Mining Co. v. Industrial Commission*, the Illinois Supreme Court held that proof of a hazardous exposure is "conclusively established" and not subject to challenge by the employer when the worker proves employment in an occupation in which the hazard exists. The Freeman court held that a worker is not required to provide any proof of the amount, time or duration of exposure. Freeman United Coal Mining Co. v. Industrial Commission,188 Ill.2d 243, 720 N.E.2d 1063 (1999). Similarly, in the instant matter the Arbitrator finds that the petitioner has established the facts that as a Firefighter/paramedic for Respondent the hazards of cancer exist and his actual exposure to carcinogens occurred while working for Respondent from 1988 through 2017. Further, in meeting this burden the Arbitrator finds under the precepts of *Freeman United Mining Co.* has conclusively established proof of a hazardous exposure that is not subject to challenge by the employer.

Any contention by Respondent that the petitioner must identify and surmount a quantum or duration of exposure to chemicals or carcinogens is contravened by a plain reading of Section 1(d) of the Occupational Disease Act, the Supreme Court's rule on exposure as explained in *Freeman United Coal* and the recent interpretation of exposure by the Illinois Appellate Court in *H&H Plumbing* and *Omron Electronics.*

Based on the entirety of the evidence, the Arbitrator finds that the preponderance of the testimonial, documentary and expert opinion evidence supports that the petitioner has met his burden of demonstrating exposure to carcinogens under Section 1(d) of the Illinois Occupational Disease Act as a result of his employment with Respondent.

On the issue of whether 's current condition of ill-being is causally-related to the occupational exposure with Respondent, "F", the Arbitrator holds the following:

There is no dispute that the petitioner developed prostate cancer with some lymphatic spread. Further, the petitioner established that he was exposed to carcinogens in the usual course of his duties as a Firefighter/paramedic for Respondent and that these are hazards for developing prostate cancer. The issue is whether Respondent has put forth sufficient evidence to rebut the presumption that his prostate cancer arose out of and the course of his employment and was causally connected to this occupational exposure. Then, the next step in the analysis is if Respondent has rebutted the presumption, has the petitioner otherwise met his burden by a preponderance of the evidence that his occupational exposure during his employment with Respondent was 'a' causative factor in the incidence or accelerated manifestation of his prostate cancer.

Under the Illinois Workers' Occupational Diseases Act, firefighters employed in the profession for five years prior to diagnosis benefit from a presumption that:

"Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician, or paramedic **which results directly or indirectly from** any blood-borne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis or **cancer**...resulting in any disability to the employee shall be *rebuttably presumed to arise out of and in the course of the employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment.*"

820 ILCS 310/1(d).

The petitioner was employed as a firefighter for Respondent for 29 years prior to the diagnosis of prostate cancer and therefore his prostate cancer is **presumed** to arise out of and in the course of employment **and** be causally connected to the hazards or exposures of the employment.

The Arbitrator finds that irrespective of the quantum of evidence needed to rebut the presumption the Respondent has failed to do so because the testimony of Section 12 examiner, Lev Elterman, M.D., was unreliable as lacking foundation in science or fact. The Arbitrator notes that the only evidence Respondent tendered on the issue was the testimony of Lev Elterman, M.D.

Initially, "the proponent of expert testimony must lay a foundation sufficient to establish the reliability of the basis for the expert's opinion" *Sunny Hill of Will County v. Illinois Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, ¶ 36. The issue in dispute is whether the occupational exposures of (a firefighter) were 'a' causative factor in his incidence or accelerated manifestation of prostate cancer. Dr. Orris contrasted the difference in approach between an epidemiologist/occupational medicine doctor and a clinician like Dr. Elterman. The job of an epidemiologist/occupational physician is to identify risk factors in the environment, so they can intervene in a preventative way; where a clinician's primary orientation, appropriately, is to diagnose the disease and propose treatment.

Apart from knowledge of a firefighter's exposure, the medical specialities which may be probative on the relevant issue include public health, toxicology, epidemiology and occupational medicine – not familiarity with general urology or even cancer treatment. Dr. Elterman has no training, education or experience in public health, toxicology, epidemiology or occupational medicine. Dr. Elterman agreed that the extent of his understanding of Petitioner's work history or exposure is that he was a fire fighter. The Arbitrator notes that mere awareness of the existence of a vocation does not inform an expert with detailed knowledge of the specific occupational exposure of that vocation. Dr. Elterman admitted that he had no understanding of the common occupational exposures of a firefighter and no knowledge of the chemical composition of smoke or fire.

There is no dispute that Dr. Elterman is a treating urologist who appears competent to treat general urological disorders, but knowledge of the clinical treatment of urological orders is not probative of any material issue. Further, Dr. Elterman agreed on cross examination, as a clinician, that environmental exposures are of no benefit to patients who have already been diagnosed with cancer and see him for treatment. The Arbitrator finds that Dr. Elterman does not possess an adequate history of Petitioner's occupational exposures. Further, the Arbitrator finds that Dr. Elterman does not possess education, training or experience which would provide

him an adequate scientific foundation to provide probative testimony on whether the occupational exposures of (a firefighter) were 'a' causative factor in his incidence or accelerated manifestation of prostate cancer. As such, the Arbitrator finds that Dr. Elterman does not have the education, training or experience in a relevant discipline to provide credible and reliable testimony.

Based upon the entirety of the evidence, the Arbitrator finds that Dr. Elterman lacks foundation to provide probative or reliable testimony on the sole material issue and his testimony is insufficient to rebut the presumption under ¶1(d) of the Illinois Occupational Diseases Act that Petitioner's diagnosis of prostate cancer arose out of and in the course of his employment and is causally connected to the hazards or exposures of the employment.

In addition to Dr. Elterman's lack of qualification by education, training or experience to testify reliably in this matter, the Arbitrator finds that the underlying basis for Dr. Elterman's opinion "that the medical literature paints, at best, a contradictory causal relationship or that Petitioner's occupational exposure as a fire fighter is not 'a' causative factor in the development or accelerated manifestation of prostate cancer" is not soundly based in qualifications, fact or knowledge of the scientific literature.

Expert opinions must be supported by facts and are only as valid as the facts underlying them. *Hiscott v. Peters,* 324 Ill.App.3d 114, 123 (2001); *In re Rovelstad,* 281 Ill.App.3d 956, 969–70 (1996). 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, "opinions must be supported by facts and are only as valid as the facts underlying them." *Hiscott, at* 123.

The Arbitrator finds it noteworthy that Dr. Elterman admitted he had no understanding of the common occupational exposures of a firefighter, no specified knowledge of Petitioner's work history and no knowledge of the chemical composition of smoke or fire. Although, he acknowledged carcinogens are present in a fire fighter's environment but had no knowledge of what they could be. The Arbitrator notes that he possessed no understanding of the medical literature on the subject of fire fighter's occupational exposure and the development of prostate cancer. Further, the study that he did quote in support of his opinion demonstrated excess incidence of prostate cancer in firefighters in Chicago; and on cross examination he agreed that his *Daniels* study included two separate conclusions of excess prostate cancer (*in Chicago*

firefighters) and he ultimately agreed that his study tended to show a connection between firefighters' occupational exposure and prostate cancer.

Further, the Arbitrator finds that Dr. Elterman did not appear to have an understanding of and was unable to accurately articulate the findings of the study he purported to rely on. When confronted with several studies, including his own, which supported an increased incidence of prostate cancer among Chicago firefighters as compared with the general population, he did not answer and did not provide rebuttal. He admitted that he did not know whether firefighters get prostate cancer at a younger age than the general population.

Dr. Elterman denied causation on the theory that Petitioner's father's prostate cancer diagnosis was likely the cause of his prostate cancer. However, he was unable to demonstrate knowledge of the median age of prostate cancer diagnosis for men in the U.S. population or the age of incidence of prostate cancer one would expect of someone whose father had prostate cancer explaining it wasn't relevant to his practice. He was unable to demonstrate knowledge or testify on the percentage of those who developed prostate cancer that had a positive family history of prostate cancer. The Arbitrator finds that Dr. Elterman's lack of knowledge on these points supports his lack of qualification to opine on any topic having to do with the incidence of prostate cancer. Further, on cross examination he agreed that having a family history of prostate cancer does not negate the contribution of other factors to the development of prostate cancer; he agreed that environmental factors can contribute to prostate cancers, and that there is no test which can delineate these various contributions to the development of cancer.

Thus, the presumption of causation in this case requires the fact finder to presume that the claimant's occupational exposures of (a firefighter) were 'a' causative factor in his incidence or accelerated manifestation of prostate cancer. In order to rebut this presumption, the respondent had to introduce evidence sufficient to support a contrary finding (*i.e.*, a finding that the claimant's employment was not a contributing cause of his prostate cancer). The Respondent could do this by presenting expert testimony that: (1) exposure to smoke, particulate matter or toxic fumes while fighting fires is not a risk factor for the development of prostate cancer; or (2) the 's particular level of exposure to carcinogens on the job did not casually contribute to the development of his prostate cancer. *Simpson v. Illinois Workers' Comp. Comm'n,* 2017 IL App (3d) 160024WC, ¶ 55.

Based upon the entirety of the evidence, the Arbitrator finds that the testimony of Dr. Elterman was not sufficient in rebutting the presumption. Further, the Arbitrator finds that on cross examination Dr. Elterman conceded the literature demonstrated a causal connection between a firefighters' occupational exposure and the incidence of prostate cancer.

Petitioner's Affirmative case for Causation

Respondent may assert that the petitioner must prove his diagnosis of prostate cancer was directly caused by his occupational exposure to sustain this burden. However, this is not the requisite statutory standard. The relevant portion of the Section 1(d) of the Illinois Occupational Diseases Act states:

> "**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 need 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."

820 ILCS 310/1(d) (January 1, 2014).

This burden was explained by the Illinois Supreme Court in *Sperling:*

> "Nothing in the statutory language requires proof of a direct causal connection. Further, the legislature explicitly changed this requirement in 1975 when it deleted the word "direct," which had preceded "causal connection," from the statutory language. Public Act 79-78, approved June 30, 1975, rewrote the first two paragraphs of subparagraph (d) of section 1 and eliminated the requirement that it be apparent that there is a *direct* causal connection.

Sperling v. Industrial Comm'n, 129 Ill. 2d 416, 421 (1989)."; followed by *Omron Electronics v. IWCC, et al.*, No. 1-13-0766WC, 2014 IL App. (1st) WL 130766WC (November 14, 2014)."

A causal connection may be based upon an expert's opinion that an accident "could have" or "might have" caused an injury. *Omron Electronics v. IWCC,* 2014 IL App. (1st), 130766WC, ¶38.

Under the Illinois Workers' Occupational Diseases Act in order to establish causation, a claimant need only prove that some act or phase of his employment was *a* causative factor in his ensuing injuries. *Sisbro, Inc. v. Industrial Comm'n*, 278 Ill. Dec. 70 (2003); *Land and Lakes Co.*

v. Industrial Comm'n, 296 Ill. Dec. 26 (2005). Further, the presence of an increased risk of cancer from family history does not negate the contribution of 29 years of occupational exposure to carcinogens.

In light of a lack of a requirement of direct causal connection under the Occupational Disease Act, the applicable presumption of §6(f) that the disease both arose out of and in the course of employment and was causally connected to occupational exposure the arbitrator weighs whether by a preponderance of the evidence 's demonstrated that Petitioner's occupational exposure was 'a' causative factor in the development or accelerated manifestation of his prostate cancer.

The Arbitrator finds that Petitioner was a credible witness. Further, the Arbitrator finds that his unrebutted testimony and documentary evidence reflected over 23,000 on-scene call responses to structural, residential, commercial and automobile calls as a first line responder over the 29 years as a firefighter for respondent. Further, he provided a chronology of exposure and weekly call volume by fire house where he was based during various periods of his career (including mutual aid calls): 1988-1994, 1994- early 2000's, 2001-2005, and 2005 through 2017. Further, it is noteworthy that the summary produced by the Respondent exempted any record of automobile response calls from 2005 through 2017 resulting in the Respondent's official under-reporting of thousands of responses of possible exposure.

The Arbitrator finds that the respondent was unable to provide any call summaries between 1988 through 2005; the Petitioner's testimony on weekly call volume is unrebutted for this period of time. The Arbitrator finds that the Respondent failed to put forth any affirmative documentary or testimonial evidence on types of exposures, numbers of calls or any evidence relevant to the occupational exposure of the petitioner. Further, the Arbitrator finds that Petitioner's testimony on the minimal use of respirator/masks or respiratory protection was unrebutted and corroborated by the testimony of Dr. Orris. Further, the Arbitrator found Petitioner's detailed testimony of the types of exposure credible and persuasive on the subjects of outdoor fires, response to vehicular crashes, fire suppression, over haul period, inadequate gear hygiene, exposure at common areas at firehouse, exposure to diesel exhaust, and disruption of circadian rhythms.

The Arbitrator finds that the background, education and training of Dr. Orris lends great credibility to his opinions both on exposure and causation. He is current Chief of Occupational

Medicine at the University of Illinois-Chicago Health System since 2001, and has prior decades of experience in epidemiology, public health, occupational health, toxicology and environmental medicine. He is board-certified in three of these specialties. Further, his knowledge of the medical literature specific to the occupational exposure of firefighters is grounded in the participation in one of the original Studies by the National Institutes of Occupational safety and health studies of cancer incidence of actual firefighters in Chicago in 1988. Further, since that time it has been his ongoing practice to review subsequent studies on the subject matter.

The Arbitrator found Dr. Orris had a very detailed knowledge of Petitioner's work history with the respondent, including his length of fire service, the number of calls per week and their breakdown by type. Further, he possessed and ably articulated a specific knowledge of the type of exposures and carcinogens/toxins commonly encountered by firefighters including those connected to live fire suppression, overhaul, off-gassing, wearing dirty protective gear, insufficient use of respirators, sharing space in a contaminated firehouse environment and exposure to diesel exhaust. These were informed by his extensive experience working with fire departments on mitigating occupational exposures. Further, he testified on the basis of his knowledge of the medical literature of the connection between the presence of carcinogens stemming from combustion of newer building materials.

Based on the entirety of the evidence and pursuant to *Sunny Hill*, the arbitrator finds the petitioner established a sufficient foundation for the reliability of Dr. Orris' bases for his expert opinions on exposure and causation.

The Arbitrator finds that Dr. Orris testified as to the median age of cancer diagnosis for men in the United States and was therefore credible and persuasive in opining that the early expression of prostate cancer in someone's 40s or 50s would be an acceleration over and above that which is experienced by the general population. Further, and in contrast to Dr. Elterman, Dr. Orris had knowledge and did testify that only 10% of all prostate cancers are the results of a contribution from genetic or family history.

Given the strong and credible foundation in education, experience in the relevant disciplines, strong foundation in the epidemiological medical literature, familiarity with fire fighter's exposure vectors and Petitioner's occupational history, the Arbitrator adopts Dr. Orris' opinions as credible and persuasive – specifically, Dr. Orris' opinion that the petitioner had increased exposure to carcinogens as a result of his occupation as a firefighter; that Petitioner's

elevated PSA in his forties has some relationship with his occupation exposure as supported by the literature reflecting that firefighters will develop prostate cancer at an earlier age than the general population; his opinion that Petitioner's medical history of earlier expression of cancer is consistent with the medical literature of firefighters having an earlier date of manifestation. Dr. Orris testified that Petitioner's occupation as a firefighter over this period of time was the cause of his prostate cancer as well as the metastatic spread to his lymph nodes.

A causal connection may be based upon an expert's opinion that an accident "could have" or "might have" caused an injury. *Omron Electronics v. IWCC,* 2014 IL App. (1st), 130766WC, ¶38.

Clearly, the petitioner was exposed to carcinogens. The claimant's exposure to carcinogens created a risk of contracting prostate cancer which was greater than the risk to the general public. The petitioner was also exposed to that risk in a manner different from the general public. The Act was interpreted in *Allis-Chalmers Mfg. Co. v. Industrial Com.* (1965), 33 Ill.2d 268, 271, 211 N.E.2d 276, 278 to allow recovery where an employee's disease resulted from "exposure to hazards of a peculiar or unusual condition of work in a greater degree and in a different manner than the public generally". *Allis-Chalmers Mfg. Co. v. Industrial Comm'n.*, 33 Ill.2d 268, 271, (1965); *Zupan v. Indus. Comm'n*, 142 Ill. App. 3d 127, 131 (5th Dist. 1986).

Based on the entirety of the evidence, in light of a lack of a requirement of direct causal connection under the Occupational Disease Act, the applicable presumption that the disease both arose out of and in the course of employment and was causally connected to occupational exposure codified in §6(f) of the Illinois Occupational Diseases Act and the credible testimony of Dr. Orris, the Arbitrator finds that the petitioner met his burden of proof by the preponderance of the evidence that his occupational exposure was 'a' causative factor in the development or accelerated manifestation of his prostate cancer and that his cancer had its origin or aggravation in a risk connected to his occupational exposure as a firefighter/paramedic for Respondent.

On the issue of reasonable and necessary medical services and reimbursement of medical expenses, "J" & "O", the arbitrator holds the following:

The petitioner alleged $469,671.94 in unpaid medical expenses, Respondent claims a §8(j) credit that they were paid under respondent's group carrier and the petitioner demands strict proof as to the amount of the credit. In reviewing Petitioner's bills list, it reflects related bills

pain to the providers as reflected totaling $469,385.35 for payments made to St. Alexius Medical Center, Rush University, Northwest United Urology, URO Partners, Advocate Health, Radiology Consultants Woods, University Anesthesiologists, University Pathology Diagnostics, Alpha Med Physicians Group and the remaining unpaid bills of $179.60 to Swedish Covenant and $499.00 to Dr. Paik of Northwestern United Urology. (PX 12).

The Arbitrator finds that both medical experts testified that all care rendered to Petitioner was reasonable. In accordance with the finding on causal connection and based upon a review of the totality of medical evidence, the Arbitrator finds the medical treatment to date to be reasonable, necessary and related to Petitioner's occupational exposure with the respondent. As such, the arbitrator awards the petitioner the medical expenses totaling $470,063.95, pursuant to fee schedule and subject to credit to the respondent under section 8(j) of the Act.

Per the parties' stipulation, the petitioner has agreed to Respondent's credit for medical expenses paid by its group carrier under §8(j)(1) in the amount of $469,385.35, and per the language of §8(j)(1), Respondent will indemnify and hold Petitioner safe and harmless from any and all claims for liability by Blue Cross Blue Shield to the extent of these payments. Otherwise, the Arbitrator awards the following medical bills to Petitioner of $179.60 to Swedish Covenant and $499.00 to Dr. Paik of Northwestern United Urology.

On the issue of the period of temporary total disability, "K", the arbitrator finds as follows:

The petitioner indicates an entitlement to temporary total disability benefits from May 17, 2017, through January 30, 2018. Respondent agreed that the medical records reflect that the petitioner was disabled for the period claimed. The arbitrator finds based upon the testimony of the petitioner and the medical records that Petitioner was restricted from work and awards temporary total disability benefits for this period.

Petitioner's AWW is $2,224.28, TTD rate $1,435.17. Petitioner is owed 36-6/7 weeks in temporary total disability benefits of $52,900.37. The Respondent shall pay Petitioner $52,900.37 in temporary total disability benefits.

On the issue of §8(j) credit against liability for TTD, "N", the arbitrator finds as follows:

Respondent alleges under §8(j) of the Act that it should receive a credit for sick pay used by the petitioner against its liability for TTD and the petitioner disputes that a credit should be awarded for sick pay under §8(j) and demands strict proof.

Section §8(j) of the Act: Benefits Received Under Group Health Plan states as follows:

1. In the event the injured employee receives benefits, including medical, surgical or hospital benefits **under any group plan covering non-occupational disabilities** contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, **shall be credited to or against any compensation payment for temporary total incapacity for work** or any medical, surgical or hospital benefits made or to be made under this Act...**This paragraph does not apply to payments made under a group plan which would have been payable irrespective of an accidental injury under this Act.**

820 ILCS 305/8(j)(1) (West 2002).

The right to credits, which operates as an exception to liability created under the Act, is narrowly construed. *World Color Press v. Industrial Comm'n,* 466 N.E.2d 270 (1984). Further, in *Hill Freight Lines,* the Supreme Court found that the burden is upon the employer to establish the fact that it is entitled to credits under section 8(j) of the Workmen's Compensation Act. It was therefore incumbent upon the employer to see that sufficient evidence of the insurance contract itself was introduced in order to determine if it fell within the provisions of §8(j). *Hill Freight Lines, Inc. v. Indus. Comm'n*, 36 Ill. 2d 419 (1967).

Respondent put forth no evidence that sick time was a benefit from a "group plan covering non-occupational disabilities" as required by a plain reading of §8(j)of the Act for respondent to acquire a credit. Further, a plain reading of the second half of §8(j)(1) is that the paragraph, i.e. a credit does not apply for payments that would have been payable irrespective of an accidental injury under this Act.

The Commission stated that under *Tee–Pak, Inc.,* an employer receives no credit under §8(j)(1) for benefits which would have been paid irrespective of the occurrence of a workers'

compensation accident. In that case the Commission noted that claimant testified that she had not received full salary in lieu of TTD benefits but that she had to utilize earned sick pay to do so. As a result respondent was not entitled to a section 8(j) credit for salary paid to claimant in lieu of TTD benefits because§8(j) does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. *Elgin Bd. of Educ. Sch. Dist. U-46 v. Illinois Workers' Comp. Comm'n*, 409 Ill. App. 3d 943, 953(1st Dist. 2011); *quoting Tee–Pak, Inc. v. I.W.C.C.*, 141 Ill.App. 3d 520 (1986). Further, pursuant to section 8(j) 2 of the Act (820 ILCS 305/8(j) 2 (West 2002)), respondent is entitled to credit for salary paid to claimant, but only to the extent of its TTD liability. *Elgin Bd. At* 954. Accordingly, Respondent's payment of sick pay and vacation pay would not be eligible for a credit under *§8(j).*

Further, Respondent offered no evidence on the classifications of pay as reflected in Respondent's exhibit #5 and it is respondent's burden to substantiate its basis for a credit. In reviewing Respondent's exhibit #5 and counting the sum of only those payments which are not identified as "sick time" or "vacation" from 5/19/2017 through 1/30/2018 totals $3,029.00.

Based on the entirety of the evidence, the Arbitrator finds that Respondent is due a credit totaling $3,029.00 pursuant to §8(j) against its liability for TTD.

In support of the Arbitrator's decision relating to "L", the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator finds, based on the petitioner's testimony and the medical records, that he underwent a radical prostatectomy with right lymph node dissection, non-nerve sparring for bilateral Gleason 8 bilaterally. Complications of recurrence, incontinence and erectile dysfunction were discussed. The pathology report reflected Adenocarcinoma, Grade Group 4(Gleason Score 8) involving both lobes and associated with focal extra prostatic extension and vas deferens invasion. Further, invasion of lymph-vascular, surgical margin positive for malignancy with tumor involving the right lateral margin, apex and base margins; Stage pT3aN0. Further, the percentage of the prostate involved by tumor was 14/23 blocks involved.

Dr. Mehta was concerned about the high PSA values post-operatively and saw enlarged pelvic lymph nodes on CT consistent with lymph node metastasis and the petitioner underwent

an extensive course of radiation and hormone treatment that continues at least through April of 2019. Further, he has scheduled follow ups with Drs. Mehta and Coogan. had cancer of the prostate with some metastasis into the lymphatic and vas deferens. Further, the medical evidence in demonstrating ongoing treatment 2 years following the removal of the prostate corroborates Dr. Orris testimony that the need for future treatment is foreseeable due to the metastatic spread. The probable recurrence of this cancer carries with it the probability of early death due to cancer.

The cancer treatment caused impotence that required surgical implantation of a device to enable the petitioner to achieve erection.

Based on the entirety of the evidence, the Arbitrator awards the petitioner permanent partial disability to the extent of 40% loss of use of the man as a whole or 200 weeks compensation benefits under section 8(e) of the Act. The rate of permanency is $775.18 for these dates of exposure. The arbitrator awards a sum of $155,036.00 in permanent partial disability benefits.

In support of the Arbitrator's decision relating to "M", whether Respondent is liable for Penalties under Sections 19(k) or 19(l) and attorney's fees under Section 16, the Arbitrator finds as follows:

Based on the entirety of the evidence, the respondent had good faith disputes regarding both facts and law; and its actions were not unreasonable, vexatious or dilatory. Accordingly, penalties and fees are denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC012378
Case Name	FASSO, JONELL v. MENARD'S DISTRIBUTION CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0417
Number of Pages of Decision	15
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Thomas Strow
Respondent Attorney	Robert Doherty

DATE FILED: 8/17/2021

/s/Marc Parker, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janell Fasso,
Petitioner,

vs. No. 16 WC 012378

Menards,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the sole issue of nature and extent of permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

With regard to the nature and extent of Petitioner's injury, the Commission notes that the Arbitrator properly considered and weighed each of the five factors required by §8.1b(b) of the Act. However, the Commission finds the Petitioner sustained permanent partial disability to the extent of 35% of the person-as-a-whole and modifies the Arbitrator's award accordingly.

All else is affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the statutory minimum of $319.00 per week for a period of 175 weeks, as provided in §8(d)2 of the Act, because the injury sustained caused a 35% disability of the person-as-a-whole.

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 $55,900.00.The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 17, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-8/5/21
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/s/ *Barbara N. Flores*
Barbara N. Flores

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FASSO, JANELL
Employee/Petitioner

Case# **16WC012378**

MENARDS INC
Employer/Respondent

On 9/23/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5709 STROW LAW LLC
THOMAS STROW
716 COLUMBUS ST
OTTAWA, IL 61350

0445 EVANS & DIXON LLC
ROBERT J DOHERTY JR
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

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
NATURE AND EXTENT ONLY

Janell Fasso
Employee/Petitioner

v.

Menards, Inc.
Employer/Respondent

Case # **16** WC **12378**

Consolidated cases:

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 31, 2020**. By stipulation, the parties agree:

On the date of accident, **April 12, 2016**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**18,269.16**, and the average weekly wage was $.

At the time of injury, Petitioner was **31** years of age, with **3** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**3,646.82** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,646.82**.

ORDER

- Petitioner sustained injuries that caused **30% loss of use of the person-as-a-whole**, for which, Respondent is liable as provided in Section **8(D-2).** (See the Arbitrator's Addendum for her analysis pursuant to Section 8.1(b) of the Act).
- Respondent shall pay Petitioner compensation that has accrued from **3/10/17 through 4-17-17 and 1-14-19 through 1-27-19 and 6-24-19 through 8-18-19, representing 15 5/7 weeks** and shall

pay the remainder of the award, if any, in weekly payments. **Respondent shall receive a credit of $3,646.82 for TTD payments already made.**

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

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

Jason C. Mozenter

Signature of Arbitrator

9/21/2020

Date

SEP 23 2020

STATE OF ILLINOIS)
)
COUNTY OF)

ILLINOIS WORKERS' COMPENSATION COMMISSION

JANNELL FASSO
Employee/Petitioner

v. Case # 16 WC 12378

MENARDS, INC.
Respondent/Employer.

ADDENDUM TO THE DECISION OF THE ARBITRATOR

The parties stipulated that Petitioner, Jannell Fasso, was an employee of Menards, Inc. ("Respondent"), on April 12, 2016 sustained accidental injuries that arose out of and in the course of her employment. (Arb. 1). The only issue in dispute is the nature and extent of Petitioner's injuries. (Id.).

Petitioner began working for Respondent in the shipping and receiving department of their distribution center in July of 2015 and worked the same duties that required frequent bending, standing, and lifting boxes up to 50 pounds on and off a forklift, which she also drove. (Id. at 10-12).

Prior to her work-related accident, Petitioner never experienced physical problems with her left foot and had no physical work restrictions or limitations. (T. at 13).

Petitioner testified that on April 12, 2016 a forklift truck ran over her left foot. (T. at 8). The following day she reported to Rush Copley Occupational Medicine Clinic where she reported a history of standing at a table sorting sticks when a co-worker operating a fork lift truck pulled close to her, running over the top of her left foot with the lift forks. The co-worker then backed up and ran over Petitioner's left foot again. (PX8). Petitioner reported numbness across the base of her left toes and that they felt raw to the touch. Bruising and swelling was noted across the dorsal 1st-4th MTP joints. Petitioner was diagnosed with a crush injury to her left foot, fitted with ACE and an ortho. shoe and instructed to ice, elevate, and follow-up in a few days. (Id.).

On May 14, 2016 Dr. George Holmes at Midwest Orthopaedics at Rush noted Petitioner's complaints of pain over the dorsal aspect of her left foot in the 2nd to 3rd MTP joints and from the 2nd to the 5th MTP joints with numbness, swelling, and occasional radiation to the toes following a crush injury on April 12, 2016. (PX5). Petitioner indicated it hurt to walk and bend her left foot. Dr. Holmes noted a horizontal scar on the dorsal aspect behind the MTP joints. Dr. Holmes diagnosed a contusion with subsequent neuritis for which he recommended various conservative treatment modalities and sedentary work until full healing had been accomplished. (Id.).

Petitioner underwent conservative treatment, including physical therapy at ATI/Atlas between May 30 and August 4, 2016 when she was discharged because she had begun to plateau in therapy and was experiencing minimal pain relief of pain with persistent soft tissue tightness. (PX7).

On June 24, 2016 Dr. Stephen Joyce at Rush-Copley Occupational Medicine noted Petitioner's complaints of throbbing and shooting pain going from her left foot up her leg. (PX6). Dr. Joyce ordered an MRI and referred Petitioner for a podiatry consult. (Id.).

On July 1, 2016 MRI of Petitioner's left foot noted:

1. Incomplete fat saturation involving the distal forefoot/toes somewhat limits evaluation;

2. Signal changes involving the fifth metatarsal head and the proximal/middle/distal phalanges of the third – fifth digits/toes may be related to mild bone marrow edema/reactive changes versus mild bone contusions. Otherwise no obvious fractures.

3. Mild intermetatarsal bursitis at the first-second and second-third interdigit spaces. (PX8).

On July 11, 2016 podiatrist, Dr. Paul Bishop at Foot & Ankle Centers in Yorkville, Illinois noted Petitioner's complaints of persistent pain over the dorsal aspect of her left foot. (PX6). The doctor reviewed the recent MRI noting marrow edema of her digits but no obvious signs of fracture. On exam, thickening of the dorsal tissue over the 2nd, 3rd, and 4th joints was noted. Petitioner began physical therapy with massage, ultrasound, and e-stim. Petitioner continued to follow-up with Dr. Bishop who administered a peroneal nerve block over the top of Petitioner's left foot on December 1, 2016 pursuant to her complaints of pain and swelling. (Id.).

On December 28, 2016 Dr. Bishop noted Petitioner's complaints of persistent pain and bone throbbing in the 3rd, 4th and 5th metatarsal heads at the base of her toes. (Id). Dr. Bishop recommended an ultrasound bone growth stimulator noting that Petitioner had more than six months of pain secondary to a crush injury with evidence of bone marrow edema and swelling. (Id).

That request was non-certified pursuant to utilization review.

On March 14, 2017, Dr. Bishop noted Petitioner's complaints of increased pain in the last four weeks. (Id.). On exam, the doctor noted "modeling" of the skin and that Petitioner's left foot was "somewhat cool". Petitioner reported that she can notice when the shower water starts hitting her left foot and it is somewhat more noticeable if she gets some color change in the foot. Dr. Bishop noted this may be suggestive of early CRPS. Dr. Bishop reviewed recent MRI, noting a very small area of interdigital intermetatarsal bursitis and a very slight increase in signal of the 4th metatarsal head possible indicating a stress injury. The doctor recommended Petitioner consult with a specialist for evaluation of CRPS and RSD Stage 1 left foot, secondary to injury. (Id.).

On April 13, 2017 Petitioner presented to Dr. Timothy Lubenow at the Rush University Pain Center with complaints of constant aching and throbbing pain on the dorsum of the left metatarsals worse with walking or standing for over an hour. (PX4). Petitioner reported persistent daily color changes (red and white) in her left foot. (Id.). Dr. Lubenow reviewed MRI from March 17, 2017 noting the following:

- Minimal joint effusion in the 1st MP joint;
- Mild interstitial bursitis at the 1st-2nd and 2nd-3rd interdigit spaces;
- Minimal/mild intermetatarsal bursitis at the 3rd-4th interdigit space;
- Edema/reactive changes along the plantar aspect of the forefoot, underlying subtle Morton's neuroma may potentially demonstrate a similar appearance;
- Mild edema/reactive changes involving the abductor digiti minimi muscle and adjacent soft tissues. (Id.).

On exam, Dr. Lubenow noted decreased dorsiflexion and plantarflexion in the left foot and a 2 degree decrease in temperature difference at the distal half of the left dorsum foot than that of the right. Decreased pinprick sensation over the distal half dorsum of the left foot was also noted. The doctor noted a diagnosis of left foot bursitis and neuropathic pain recommending Meloxicam, Gabapentin and home exercises. Petitioner was to follow-up in six weeks for a Dorsal Root Ganglion ("DRG") trial (Id.).

Petitioner continued treatment with Dr. Lubenow who remained her primary doctor for this injury through the date of trial. (PX4).

By May 2018, Dr. Lubenow's notes reflect Petitioner had been seen for an IME by Dr. Candido, who recommended a nerve block prior to the DRG trial.

Respondent did not offer Dr. Candido's report or opinions as evidence at trial.

Dr. Lubenow followed the IME's recommendation and ordered 3 nerve blocks, which occurred in June 2018. (PX4). The nerve blocks were ultimately unsuccessful. Dr. Lubenow renewed his request for the trial stimulator on August 30, 2018, over a year after his initial recommendation.

Following a successful psychological examination, the trial stimulator was implanted on January 14, 2019 at Rush Surgicenter. (PX4, PX2). On January 13, 2019, Petitioner noted an almost 90% improvement of her pain due to the trial stimulator. Due to its success, Dr. Lubenow recommended a permanent implant. (PX4).

Petitioner underwent a permanent DRG stimulator implant at L4 and L5 of her spine on June 24, 2019. (PX4, PX2).

Petitioner completed 10 visits of therapy at ATI between August 9, 2019 and September 19, 2019, with Petitioner reporting no improvement of her pain during those treatments. (PX7). Further, she stated that prolonged weight bearing continued to be aggravating as well as stairs, stepping up/down from higher surfaces, and walking on uneven surfaces. (Id.).

On September 16, 2019, Petitioner underwent a Functional Capacity Assessment ("FCA"), deemed valid, at ATI. (PX7). According to the FCA report, Petitioner's occupation at the time of her work accident was classified at medium demand level under the Dictionary of Occupational Titles. The FCE examiner concluded that Petitioner's physical demand level was in the light duty category. The FCA noted "[t]he client's capabilities falls [sic] below the DOT and the client's self-stated level."

On September 19, 2019, Dr. Lubenow released Petitioner with permanent restrictions of no lifting over 20 pounds. The doctor also advised Petitioner "not to over-exert herself at work to avoid pain flare up." (PX4).

On December 4, 2019 Dr. Lubenow noted Petitioner's report that she had returned to work and initially had worsening pain with the increased activity level, however she was prescribed a Medrol dose pack which helped and she had subsequently made some changes with her DRG settings that brought her pain down below where she was prior to her DRG implantation. (Id.). She also noted worsening of her pain with cold weather, however she felt that her DRG was working well. Petitioner also complained of pain over the IPG (right low back) after wearing jean during her workday. Petitioner was counseled on various methods for adding padding over her DRG site. (Id.).

At trial, Petitioner testified that she is to follow up with Dr. Lubenow at six-month intervals, essentially to make sure her pain is controlled by the stimulator. (T. at 9, 23-24).

Regarding her current level of pain, Petitioner credibly testified that the DRG stimulator has allowed her to be pain-free at times, though she continues to experience symptoms of tingling and cramping and has both good and bad days. (Id., at 10, 24). She carries an iPod-type device to adjust the stimulator when she has pain. (Id., at 15).

Petitioner testified credibly about her job duties before the accident. She began working for Respondent in the shipping and receiving department of their distribution center in July of 2015 and worked the same job duties until her work-related accident which included frequent bending, standing, and lifting boxes up to 50 pounds, "if not a little more" on and off the forklift. She also drove a forklift truck. (T. at 10-12). Prior to her work-related accident, Petitioner never experienced physical problems with her left foot and had no physical work restrictions or limitations. (T. at 13). Following the accident, Petitioner has permanent light duty restrictions. Although her restrictions have been accommodated by Respondent and her wages have increased, Petitioner only operates a forklift now. She does not do any lifting of any kind at the distribution center now, "I don't have to get off my forklift. I just sit and put out pallets all day. There is no physical activity." (Id., at 14). Petitioner testified that she is the only worker who drives a forklift exclusively. All the other forklift drivers get off their forklifts and lift packages. (T. at 22-23, 29-30). Petitioner credibly testified that now has trouble standing for long periods of time, walking long distance and trying to run. (Id., at 18).

Petitioner credibly testified that her physical limitations have affected her daily life "tremendously" noting, "My children are young. They are very active. They want their mother to participate in activities and I have difficulty doing that." Such activities with her children include sports, dance, and gymnastics. She further testified that her son now helps with tasks related to lawn care which she used to perform herself without issue. (Id., at 19-20). Although she was married at the time of this accident, she has since divorced and does not receive child support for her dependent children, ages 6, 7, and 10. (Id., 11).

Petitioner testified that over the last year she has been able to work most of the hours that Respondent has provided. (Id., at 15). She further testified that while performing her work in the past year she has not been asymptomatic will adjust her iPod pain device to bring her pain level down. (Id.). Petitioner has worked additional hours during the "Hop To It" program that ran from approximately April to the first week of July 2020. (T. at 17-18). The program allowed employees to

earn Menards merchandise credit, and Petitioner used the program to buy essentials for her family. (Id.). Petitioner testified the fact she has continued to work her hours does not mean she has been symptom-free, but reflects her need to care for her children. (T. at 15-16).

Respondent offered exhibits at trial including a list of weekly hours worked from October 12, 2015 to July 31, 2020, average hours worked for Petitioner in the year 2020, and a Group Exhibit of Job Performance Reviews. (RX1, RX2, RX3). Petitioner has always received generally good reviews. On the last performance review dated June 19, 2020, her manager commented that "Janell should focus on her health and getting back to full duties." (RX3).

CONCLUSIONS OF LAW

Petitioner's undisputed date of accident was April 12, 2016. According to Section 8.1(b) of the Act, 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.

Accordingly, the Arbitrator notes that no impairment report was submitted and no weight is given to this factor.

Petitioner was Petitioner was 31 years old at the time of her work-related accident. Because of her relative youth, Petitioner must live with her permanent DRG stimulator implant, restrictions, and any ongoing symptoms for the rest of her life including, presumably, many years of further employment. The Arbitrator gives greater weight to this factor.

With regard to Petitioner's future earning capacity, it is not lost on the Arbitrator that Petitioner returned to work for Respondent, albeit in an accommodated position, and has suffered no salary loss directly related to the injury. It is unclear whether Respondent will have a long-term commitment to accommodating Petitioner in her permanent light-duty status. Respondent's most recent job evaluation clearly presses her to return to full duties. Petitioner does have permanent restrictions and a permanent pain stimulator implant resulting from her work-related accident and will be restricted to light duty jobs in future employment options outside the accommodated job at Menards. Some weight is given to this factor.

The Arbitrator places greater weight on the factors of Petitioner's occupation and on the evidence of disability testified to by Petitioner and corroborated by the medical records. The Arbitrator relies on the following facts:

- The day following her injury, Petitioner reported an accident history in which she was standing at a table sorting sticks when a co-worker, operating a fork lift truck, pulled close to her running over the top of her left foot with the lift forks. The co-worker then backed up and ran over Petitioner's left foot again. Petitioner reported that her left toes felt numb and raw to the touch where bruising and swelling was noted across the dorsal 1st-4th MTP joints.

- On December 1, 2016 podiatrist, Dr. Bishop, administered a peroneal nerve block over the top of Petitioner's left foot. Later that month, Dr. Bishop recommended an ultrasound bone growth stimulator noting Petitioner had treated conservatively for more than six months but still experienced persistent pain and bone throbbing in the 3rd, 4th and 5th metatarsal heads at the base of her toes secondary to a crush injury. The doctor noted recent MRI showed evidence of bone marrow edema and swelling.

- In March of 2016 Dr. Bishop noted Petitioner's complaints of increased pain in the last four weeks, "modeling" of the skin and decreased temperature in her left foot. Dr. Bishop referred Petitioner to a specialist for evaluation of early CRPS and/or RSD.

- On April 13, 2017 Dr. Lubenow at the Rush University Pain Center noted Petitioner's complaints of constant aching and throbbing pain on the dorsum of the left metatarsals, worse with walking or standing after an hour. Dr. Lubenow reviewed MRI from March 17, 2017 and on exam noted decreased dorsiflexion and plantarflexion in the left foot, a 2 degree decrease in temperature difference at the distal half of the left dorsum foot than that of the right and decreased pinprick sensation. The doctor noted a diagnosis of left foot bursitis and neuropathic pain.

- In June of 2018 Dr. Lubenow followed Respondent's IME recommendation and administered 3 nerve blocks which were ultimately unsuccessful in mitigating Petitioner's left foot symptoms. Dr. Lubenow renewed his request for the trial stimulator which was implanted on January 14, 2019 followed by a permanent DRG stimulator implanted at L4 and L5 of the Petitioner's spine on June 24, 2019.

- Petitioner completed 10 visits of therapy at ATI between August 9, 2019 and September 19, 2019, with Petitioner reporting no improvement of her pain during those treatments. (PX7).

Further, she stated that prolonged weight bearing continued to be aggravating as well as stairs, stepping up/down from higher surfaces, and walking on uneven surfaces. (Id.).

- On September 16, 2019, Petitioner underwent a valid FCE that placed Petitioner's physical demand level in the light duty category, below that of Petitioner's medium duty job. On September 19, 2019, Dr. Lubenow released Petitioner with permanent restrictions of no lifting over 20 pounds and advised her not to over-exert herself at work to avoid pain flare up.

- Petitioner was hired in the shipping/receiving department at the Menards distribution center, a job classified under the Dictionary of Occupational Titles as falling in the "medium" physical level category.

- Petitioner concisely testified to the accommodations made by Respondent so that Petitioner could remain in the job. Specifically, although Petitioner's job title remains the same and she is actually paid more, her ability to perform in her prior capacity has changed. The work previously performed by Petitioner is now delegated. Petitioner's work restrictions against lifting more than twenty pounds is permanent. Petitioner only operates a forklift now. Petitioner is the only worker that she knows of at Respondent's distribution center who drives a forklift exclusively.

- Petitioner must carry an I-pod type device to adjust the stimulator when she has pain. She testified she has trouble standing long periods of time, walking long distance" and trying to run. She testified her limitations affect her daily life "tremendously" because her children are young, active, and want her to participate in activities she now has difficulty performing such as gymnastics and dance. Her son now helps with tasks related to lawn care which she used to perform herself without issue. She credibly testified how the injury has affected her left foot, work, family, and activities of daily living.

Accordingly, based on the foregoing analysis, the Arbitrator finds Petitioner sustained permanent partial disability under Section 8(d)(2) of the Act which allows for awards when injuries partially incapacitate one from pursuing the duties of their usual and customary line of employment but do not result in an impairment of earning capacity.

The Arbitrator found Petitioner to be an exceedingly credible witness at the hearing. She testified at length to the many ways her job duties have changed from before her injury to the present. Respondent's Exhibit 3 further corroborates the testimony of Petitioner regarding the many physical requirements of her job that she can no longer perform as well as accommodations and alterations to her daily job duties.

Based on the nature of the injury, the treatment received and on the total resulting physical impairment and disability effecting Petitioner's person as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the person as a whole under Section 8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC018641
Case Name	RODRIGUEZ,PEDRO v. ABM INDUSTRIES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0418
Number of Pages of Decision	13
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Ryan Margulis
Respondent Attorney	Lyndsay Cook

DATE FILED: 8/17/2021

/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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PEDRO RODRIGUEZ,

Petitioner,

vs. NO: 19 WC 18641

ABM INDUSTRIES,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission reverses the Arbitrator on all issues.

The Commission respectfully disagrees with the Arbitrator regarding her assessment of Petitioner's credibility, perceived inconsistencies concerning accident history and causation and reverses the Arbitrator's decision based on the following:

- Petitioner testified that the accident took place near the end of the day on Tuesday, January 29, 2019. He was using the snowblower machine and it shot forward and pulled Petitioner with it. (T. 12)
- Petitioner gave notice of the accident on the next day that he worked, Friday, February 1, 2019. (T. 14) Petitioner was typically off on Wednesdays and Thursdays.

(T. 11) Respondent agrees that notice was given to Petitioner's supervisor on February 1, 2019. (Ax1)

- Petitioner did not have any prior issues with or sought medical treatment for his bilateral shoulders prior to the accident but does acknowledge he had prior issues with his low back. (T. 11)
- Petitioner did not seek medical treatment for 5 weeks until March 7, 2019 but tried to continue working during that time. (T. 15)
- When Petitioner finally did seek treatment at Union Health between March 7, 2019 and June 18, 2019, there was no Spanish translator present. (T. 16)
- Petitioner's history of injury to Dr. Chhadia was that he was operating a snowblower when it hit a heavy piece of ice on the ground causing it to jolt forward and he fell forward onto his knee. Petitioner completed his shift and continued working until March thinking the pain would go away. (Px1, p.8) Dr. Chhadia did not find the 5-week delay in treatment to have any bearing on his diagnosis or opinions. (Px1, p. 10)
- The diagnostic results of the MRIs were consistent with Dr. Chhadia's exam of Petitioner. (Px1, p. 12)
- Dr. Chhadia causally related Petitioner's bilateral shoulder rotator cuff conditions and degenerative disc aggravation to the work accident of January 29, 2019. (Px1, p. 18)
- Dr. Chhadia opined Petitioner had a significant amount of degenerative conditions in his bilateral shoulders and back and that the work accident rendered a previously asymptomatic condition symptomatic. (Px1, p. 20)
- Dr. Chhadia does not dispute that Petitioner has degenerative bilateral shoulder and back conditions, but that they were asymptomatic prior to the accident. (Px1, p. 33-34, 37-38)
- Petitioner's prior workers' compensation claims regarding his back were in 1982 and 2005 (T. 34) – 37 and 14 years, respectively, prior to this claim. Petitioner did not deny having prior back issues, but simply did not remember his prior workers' compensation claims. (T. 34, 36)

In considering the totality of the evidence, the Commission finds that the Petitioner consistently and credibly testified he sustained a work accident on January 29, 2019 with resulting pain in his bilateral shoulders and low back. Petitioner reported the accident to his supervisor at his next shift. Although he waited to seek medical treatment for 5 weeks, this does not seem surprising given that he is in his late 70s and is still working. Presumably, Petitioner did not want to miss work or a paycheck. Petitioner had been with his current employer for 6 years prior to the accident with no prior issues, and based on the evidence submitted by Respondent, his last work injury was at least 14 years prior to the injury in the instant case.

Petitioner met his burden of proof and presented unrebutted evidence that he had no prior issues or medical treatment to his bilateral shoulders. Petitioner's treating physician,

Dr. Chhadia, opined that in addition to the rotator cuff tears there may have been a degenerative process at work – but that it was asymptomatic prior to the January 29, 2019 incident. Even Respondent's Section 12 examiner, Dr. Walsh, conceded that it is possible to have asymptomatic rotator cuff tears, or to have a pre-existing asymptomatic degenerative condition that is rendered symptomatic by trauma. (Rx2, p. 83-84) Additionally, other than the evidence that there were claims filed regarding his back 14 years and 37 years prior to this injury, there was no evidence presented to rebut Petitioner's testimony that he had been working with no problems to his lower back and had received no treatment to the low back for at least 4 years prior to this accident.

The Commission additionally finds the opinions of Dr. Chhadia more persuasive than those of Dr. Walsh. Dr. Chhadia did not dispute Petitioner's age may have contributed to his condition, but rather that the work accident is what rendered that condition symptomatic. Dr. Walsh's opinion that Petitioner's condition was solely degenerative based upon Petitioner's age simply was not persuasive.

As Petitioner proved accident and causation, Petitioner is awarded temporary total disability benefits from March 5, 2019 through the date of hearing on Arbitration. The Commission finds that there is persuasive evidence, including off work slips, to support same. Petitioner's alleged "threat" to Dr. Ortega at Union Health to keep him off of work in May, 2019 is not sufficient to negate causation and Petitioner's need to be off of work as a result of his work-related injuries.

Finally, based on a finding of accident and causation, Petitioner is awarded the medical expenses related to his shoulders and back, as well as the prospective medical treatment in the form of right rotator cuff repair surgery, left shoulder surgery, and a referral to pain management for treatment for his lower back per the recommendations of Dr. Chhadia.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $480.00 per week for a period of 51 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $821.93 to Union Health; $8,279.05 to ATI Physical Therapy and $1,731.00 to Suburban Orthopedics for a total of $10,831.98 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $35,412.00. 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.

August 17, 2021

/s/ *Maria E. Portela*

MEP/dmm
O: 6/22/21
49

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

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

21IWCC0418

RODRIGUEZ, PEDRO
Employee/Petitioner

Case# **19WC018641**

ABM INDUSTRIES
Employer/Respondent

On 5/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5019 SEIDMAN MARGULIS & FAIRMAN LLC
RYAN A MARGULIS
500 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

0000 GOLDBERG SEGALLA LLC
LYNDSAY COOK
PO BOX 957
BUFFALO, NY 41201

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)

Pedro Rodriguez
Employee/Petitioner

v.

ABM Industries
Employer/Respondent

Case # **19** WC **18641**

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 **Elaine Llerena**, Arbitrator of the Commission, in the city of **Chicago**, on **February 24, 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 Permanent Partial Disability

FINDINGS

On the date of accident, **January 29, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 $**37,440.00**; the average weekly wage was $**720.00**.

On the date of accident, Petitioner was **77** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**5,760.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,760.00**.

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

ORDER

The Arbitrator finds that Petitioner failed to prove that an accident arose out of and in the course of his employment on January 29, 2019.

Therefore, benefits are denied.

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

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

Signature of Arbitrator

May 5, 2020
Date

ICArbDec19(b)

MAY 7 - 2020

STATEMENT OF FACTS:

Petitioner testified that on January 29, 2019, he was employed by Respondent, ABM Industries, as a Custodian. (T. 9) His work entailed cleaning, maintenance and snow removal, among other activities. *Id.* Petitioner testified that prior to January 29, 2019, he was working full duty and had no prior issues nor medical treatment relative to his right or left shoulder. (T. 10) He stated that in 2015, he missed a few days of work due to back pain but had worked without issue since that time. (T. 10-11) Petitioner testified he worked eight-hour days, five days per week and was typically scheduled off on Wednesdays and Thursdays. (T. 11)

Petitioner testified that on Tuesday, January 29, 2019, he was using a snow removal machine, pushing it with both hands, when the machine struck a hard patch of ice, causing the machine to shoot forward, jerking both arms, twisting and dragging him. (T. 12) He testified that he felt pain to both shoulders and back. (T. 12-13)

Petitioner did not work the two days following the alleged accident, Wednesday and Thursday, as those were his scheduled off days. (T. 13) It was stipulated by the parties that Petitioner gave notice of the accident on Friday, February 1, 2019 to his supervisor. (AX1) Petitioner testified that he continued to work for the next five weeks but continued to have pain in his back and both shoulders. (T. 15) Petitioner testified that he modified his activities to avoid not raising his arms, which he was unable to do, and how he dusted and cleaned to minimize the use of his shoulders. *Id.*

Petitioner first sought medical care on March 7, 2019 at Union Health Service. (PX2) Petitioner complained of lower back pain and right shoulder pain. *Id.* Petitioner reported he was pushing a heavy snowblower that jumped because of ice and irritated his right shoulder. *Id.* Petitioner further explained that his lower back pain was similar to the pain he had had since January 2019. *Id.* Petitioner indicated that the alleged accident occurred on January 29, 2019. *Id.* Dr. Alex Buder noted that normal range of motion in Petitioner's shoulder on examination. *Id.* Dr. Buder took Petitioner off work until March 22, 2019. *Id.* On March 9, 2019, Petitioner indicated that he wanted to be sure that the January 29, 2019 incident was reported as a work-related incident. *Id.*

On March 21, 2019, Petitioner followed up at Union Health Service with Cynthia Siergey, NP. *Id.* Siergey noted that during examination Petitioner was barely able to stand on his toes and had very limited range of motion in his lower back. *Id.* Additionally, Siergey noted pain and very limited range of motion in Petitioner's shoulders. *Id.* Siergey kept Petitioner off work until March 28, 2019. Id. X-ray of the lumbar spine taken on March 22, 2019 revealed moderate spondylitic changes and grade 1 anterolisthesis at L4-5. *Id.* Petitioner also underwent a bilateral shoulder x-ray on March 22, 2019, the results of which revealed bilateral focal chronic calcific tendinitis and bilateral degenerative arthritic changes greater at the right glenohumeral joint. *Id.*

On March 28, 2019, Siergey ordered physical therapy for Petitioner's shoulders and referred Petitioner to ortho. *Id.* Siergey kept Petitioner off work until his ortho visit. *Id.*

Petitioner saw Dr. Djuro Petkovic, an orthopedist, on April 16, 2019. *Id.* Petitioner complained of bilateral shoulder pain and low back pain. *Id.* Petitioner reported that his shoulder pain had been going on for a few months and that he had had back problems, on and off, for years. *Id.* Petitioner reported that he suffered a fall a couple of months before and that was when his shoulder problems started to get worse. *Id.* Petitioner stated that physical therapy was helping. *Id.* Dr. Petkovic diagnosed Petitioner as having right shoulder osteoarthritis, left shoulder calcific tendinitis and lumbar spondylosis. *Id.* Dr. Petkovic continued physical

therapy, recommended shoulder injections, which Petitioner declined, and recommended that he follow up in two months to see how he was doing. *Id.* Dr. Petkovic kept Petitioner off work. *Id.*

On May 24, 2019, Petitioner returned to Union Health Services and saw Dr. Helenaida Ortega. (PX2) Dr. Ortega noted that Petitioner had presented for an eye problem, but then noted that Petitioner indicated that he was actually there to ask for his physical therapy to be extended. *Id.* Petitioner reported that he was supposed to return to work that day per his primary care physician (PCP). *Id.* Dr. Ortega advised Petitioner to get his request for more days off work from his PCP, which upset Petitioner and caused him to threaten to report Dr. Ortega. *Id.* Dr. Ortega ultimately kept Petitioner off work until his next medical evaluation. *Id.*

Petitioner underwent physical therapy at ATI Physical Therapy from April 5, 2019 through June 5, 2019. (PX4) Upon discharge, Petitioner reported continued shoulder and back pain with movement and the physical therapist noted minimum lumbar flexion and rotation. *Id.*

Dr. Petkovic re-evaluated Petitioner on June 18, 2019. (PX2) Petitioner indicated he was doing better, but still had significant pain with work. *Id.* Dr. Petkovic again offered injections. *Id.* Petitioner turned down the injections and instead requested to be off for two more weeks. *Id.* Dr. Petkovic complied with Petitioner's request. *Id.*

Petitioner testified that a friend or lady at Union Health Service gave him the name of Dr. Ankhur Chhadia. (T. 25) Petitioner did not recall reporting that he was sent to Dr. Chhadia by his attorney. (T. 25)

Petitioner saw Dr. Chhadia, an orthopedic surgeon, on July 2, 2019. (PX1-Ex.2) Petitioner complained of bilateral shoulder and low back pain. *Id.* Petitioner reported that he was pushing a snow blower when it hit a piece of ice and the snow blower jolted him forward causing him to fall on his right knee. *Id.* Petitioner further reported that the next day he awoke with low back pain. *Id.* Petitioner indicated that his bilateral shoulder pain "comes and goes" and was more of a "pressure" sensation. *Id.* Petitioner reported that lifting objects triggered his bilateral shoulder pain. *Id.* Petitioner further reported that his low back pain was constant. *Id.* Dr. Chhadia ordered MRIs of the shoulders and low back and kept Petitioner off work. *Id.*

The MRI studies were performed on July 5, 2019. (PX3) The MRI of the lumbar spine revealed grade 1 degenerative anterolisthesis of L4 upon L5; multilevel lumbar spondylosis, disc disease and fact arthrosis; severe L4-5 spinal stenosis; minimal L2-3 spinal canal narrowing; mild bilateral L5-S1 lateral recess encroachment; moderate to severe neural foraminal encroachment on the right at L5-S1; moderate neural foraminal encroachment on the left at L4-5 and L5-S1; mild neural foraminal encroachment bilaterally at L1 to L2-3, L3-4 and the right at L4-5; mild degenerative changes of the left sacroiliac joint; colonic diverticulosis; and probable right sided urinary bladder diverticulum. *Id.* The left shoulder MRI showed small interstitial tear of the anterior fibers of the supraspinatus tendon superimposed upon mild tendinosis; interstitial tear at the infraspinatus myotendinous junction superimposed upon moderate to marked tendinosis; mild biceps tendinosis; mild osteoarthritic changes of the glenohumeral and acromioclavicular joints diminutive and frayed posterior to posterior superior labrum; nonspecific abnormal signal within the superior and anterior inferior labrum; and mild subacromial subdeltoid bursitis. *Id.* The right shoulder MRI revealed full thickness tear of the anterior to mid fibers of the supraspinatus tendon with a gap and high grade partial thickness articular surface tear of the posterior most fibers; likely torn and distally retracted long head biceps tendon (not visualized); mild infraspinatus tendinosis; posterior superior labral tear and/or fraying with blunted appearance of the superior labrum; probably inferior labral tear with an adjacent paralabral cyst; nonspecific abnormal signal within the anterior inferior labrum with an adjacent paralabral cyst; mild osteoarthritic changes of the glenohumeral and acromioclavicular joints; and mild subacromial subdeltoid bursitis. *Id.*

Petitioner returned to Dr. Chhadia to review the results of the MRI's on August 6, 2019. (PX1-Ex.2) Dr. Chhadia discussed potential bilateral shoulder rotator cuff repair and recommended physical therapy. *Id.* Petitioner agreed to undergo additional physical therapy, which he underwent from August 20, 2019 through November 4, 2019. (PX1-Ex.2 & PX5) Dr. Chhadia kept Petitioner off work. (PX1-Ex.2)

On September 17, 2019, Petitioner underwent an independent medical examination (IME) with Dr. Kevin Walsh at the request of Respondent. (RX1) Dr. Walsh evaluated Petitioner in the presence of a professional interpreter. *Id.* Dr. Walsh examined Petitioner and reviewed his medical records and diagnostic exams. *Id.* Under Social History, Dr. Walsh noted that Petitioner reported no prior workers' compensation claims but that he had a current workers' compensation claim and lawsuit pending. Id. Physical examination was normal. *Id.* Dr. Walsh opined that there were no objective abnormalities to support Petitioner's complaints of subjective pain. *Id.* Dr. Walsh felt that all the findings on the MRIs could be explained as degenerative changes as none of the findings were acute in origin. *Id.* Dr. Walsh noted that Petitioner was able to work from the time of the alleged accident until March 2019 without treatment. *Id.* Dr. Walsh concluded that Petitioner's alleged conditions of ill-being were not causally related to the January 29, 2019 alleged accident. *Id.* Dr. Walsh explained that, more likely than not, the alleged January 29, 2019 incident did not cause any permanent change in Petitioner's preexisting lumbar spine condition. *Id.* Dr. Walsh further explained that Petitioner's rotator cuff pathology, including tendinosis, was more likely than not a longstanding condition and not a result of the January 29, 2019 alleged injury. *Id.* Dr. Walsh concluded that if Petitioner had acutely torn his rotator cuff, ripping the tendon from the bone, more likely than not, he would have significant pain in January 2019 and would have sought treatment for both shoulders in a timely fashion. *Id.*

On November 5, 2019, Petitioner returned to Dr. Chhadia, who discussed a bilateral shoulder rotator cuff repair, starting with the right shoulder. (PX1-Ex.2) Dr. Chhadia released Petitioner to return to light duty work. *Id.* Petitioner testified that Respondent refused to accommodate any restrictions and would only accept the Petitioner back at full duty. (T. 20) On December 3, 2019, Dr. Chhadia noted Petitioner's reported symptoms had not changed. (PX1-Ex.2) Petitioner was waiting for right shoulder surgery authorization. *Id.*

Dr. Chhadia was deposed on December 16, 2019. (PX1) Dr. Chhadia testified that the work accident caused degenerative changes in Petitioner's low back and bilateral shoulder to become symptomatic based upon the alleged mechanism of injury and Petitioner's assertions that he was asymptomatic prior to January 29, 2019. (PX1-T. 22) According to Dr. Chhadia, Petitioner reported during his initial evaluation on July 2, 2019, reporting a fall forward onto his right knee at work in January 2019. (PX1-T. 23) Dr. Chhadia did not review any medical records for Petitioner prior to July 2, 2019. *Id.*

Dr. Walsh was deposed on February 10, 2020. (RX2) Dr. Walsh's testimony was consistent with the findings, conclusions and opinions in his September 17, 2019 IME. *Id.*

Petitioner testified at hearing that his left shoulder, right shoulder and back all hurt a lot, forcing him to accommodate all the time. (T. 20) Petitioner testified that he was waiting for authorization of the right shoulder surgery and pain management for his low back. (T. 21) Regarding the left shoulder, he testified that Dr. Chhadia was going to turn his attention to that shoulder once he had recovered from the right shoulder surgery. (T. 21)

On cross-examination, after initially denying prior workers' compensation claims, Petitioner admitted that he had two prior workers' compensation claims, one in May 1982 for his back and legs and the other in August 2005 for his back. (T. 33-34) Petitioner agreed that the May 1982 claim was tried and decided by an Arbitrator. (T. 34) As for the August 2005 claim, Petitioner testified that the claim did not go to arbitration. (T. 35)

WITH RESPECT TO ISSUE (A), WAS THE RESPONDENT OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKERS' COMPENSATION OR OCCUPATIONAL DISEASES ACT, THE ARBITRATOR FINDS AS FOLLOWS:

"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). "As a general rule, the question of whether an employee's injury arose out of and in the course of his employment is one of fact for the Commission." *Bolingbrook Police Department v. Illinois Workers' Compensation Comm'n*, 2015 IL App (3d) 130869WC, 38, 48 N.E.3d 67. In resolving questions of fact, "it is within the province of the Commission to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674, 928 N.E.2d 474, 482 (2009).

Petitioner alleges unwitnessed injuries to his low back and bilateral shoulders while operating a snow blower at work on January 29, 2019. It is undisputed that Petitioner completed his shift and did not report an accident or injury on January 29, 2019, instead reporting the alleged accident on February 1, 2019, three days later. He continued to work as a Custodian and did not seek medical attention until March 7, 2019, more than 5 weeks after the alleged accident. Despite his delayed reporting and failure to seek treatment for over 5 weeks, Petitioner maintains that he suffered low back and bilateral shoulder injuries during the alleged accident on January 29, 2019.

In the context of an unwitnessed accident not immediately reported to management or corroborated by medical records, the Arbitrator places significant weight on Petitioner's credibility, which the Arbitrator finds suspect. The Arbitrator notes that Petitioner's description of the accident noticeably fluctuated as his claim progressed. Petitioner repeatedly advised medical providers at Union Health Service that the snow blower he was operating jolted, causing him to fall forward onto his right knee. Petitioner reiterated this version of events during the initial consultation with Dr. Chhadia on July 2, 2019. However, at hearing, Petitioner testified that the snow blower "shot forward and—dragged me with it and twisted me; and I was – and I fell to the ground." (T. 12) This description of the alleged accident varies from the histories in the medical records offered into evidence.

Additionally, the Arbitrator cannot overlook inconsistencies in Petitioner's testimony regarding prior workers' compensation claims. On direct examination, Petitioner admitted that he had experienced back pain in the past but denied having prior treatment to the right or left shoulder. Petitioner attempted to minimize his prior treatment to the low back, stating that he had a few days off in 2015, the symptoms resolved, and he returned to work. Petitioner testified that he had undergone physical therapy, but he could not recall the exact nature of his treatment in 2015.

On cross examination, Petitioner initially denied having any prior workers' compensation claims. When presented with evidence of a workers' compensation claim against International Harvester in 1982, Petitioner admitted not only that he had filed a claim, but that the case was litigated and decided by an Arbitrator. Petitioner testified that he had forgotten about the 1982 claim. Then, when confronted with additional evidence of a claim against Corporate Building Systems for injuries to the back in 2005, Petitioner offered no explanation except that "it really came to nothing." (T. 35) Furthermore, Petitioner reported to Dr. Walsh that he had no prior workers' compensation claims. Based on these inconsistencies, the Arbitrator finds Petitioner's credibility seriously diminished by his attempts to mislead the Arbitrator.

Also problematic is Petitioner's demand for time off work and threat to get it. On May 24, 2019, Petitioner reported that he was supposed to return to work that day per his primary care physician (PCP). When Dr. Ortega advised Petitioner to get his request for more days off work from his PCP, Petitioner threatened to report Dr. Ortega, ultimately forcing Dr. Ortega to keep him off work.

The Arbitrator also notes that Dr. Chhadia failed to offer a convincing explanation for how the alleged mechanism of injury, i.e. falling forward onto his right knee (or left knee, as subsequently claimed by Petitioner), caused significant injuries to Petitioner's low back and bilateral shoulders. Further, when Petitioner saw Dr. Petkovic on April 16, 2019, Petitioner reported that his shoulder pain had been going on for a few months and that he had had back problems, on and off, for years. That Petitioner was already suffering from bilateral shoulder and low back problems is supported by the diagnostic exam, all of which showed degenerative changes and no acute injuries.

"It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *Sisbro, Inc. v. Indus. Comm'n (Rodriguez)*, 207 Ill. At 204-205. Based on the lack of any acute findings and Petitioner's decision to not seek any treatment for 5 weeks following the alleged accident, the Arbitrator finds that Petitioner did not suffer an aggravation or acceleration of a preexisting condition on January 29, 2019. The record establishes that Petitioner's conditions of ill-being are the result of the normal degenerative process of Petitioner's preexisting conditions.

For the foregoing reasons, the Arbitrator finds that Petitioner failed to prove, by a preponderance of the available evidence, accidental injuries arising out of and in the course of his employment on January 29, 2019. In light of this finding, all other issues are moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	10WC039701
Case Name	NELSON, MICHELLE v. CHICAGO PUBLIC SCHOOLS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0419
Number of Pages of Decision	21
Decision Issued By	Maria Portela, Commisioner, Kathryn Doerries, Commisioner

Petitioner Attorney	Steven Seidman
Respondent Attorney	Kathleen Ulbert

DATE FILED: 8/17/2021

/s/Maria Portela, Commissioner
Signature

DISSENT

/s/Kathryn Doerries, 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

MICHELLE NELSON,
Petitioner,

vs. NO: 10 WC 39701

CHICAGO PUBLIC SCHOOLS,
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 benefits, temporary partial disability benefits, medical expenses, and permanency and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes a clarification as outlined below.

The Commission affirms the decision of the Arbitrator. However, on page 7 of the Arbitrator's Statement of Facts, the Commission modifies the eighth full paragraph. The eighth paragraph of page 7 of the Arbitrator's decision states:

> On July 10, 2014, Petitioner was seen by Dr. Megan Shanks at the Rush Department for Neurological Sciences. (PX6) Dr. Shanks noted that Petitioner's muscle tension neck pain and headaches were better overall. *Id.*

The Commission modifies the paragraph to state as follows:

> Petitioner was first seen by Dr. Megan Shanks at the Rush Department for Neurological Science on April 10, 2014. (PX6) On July 10, 2014, Petitioner was seen again by Dr. Megan Shanks at the Rush Department for Neurological Sciences. *Id.* Dr. Shanks noted that Petitioner's muscle tension neck pain and headaches were better overall. *Id.*

All else is affirmed and adopted.

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

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

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

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.

August 17, 2021

/s/ *Maria E. Portela*

MEP/dmm
O: 062221
49

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

DISSENT

I disagree with the majority's award of medical expenses for surgery performed at the Laser Spine Institute. Petitioner failed to prove the July 22, 2015 left L4-5 laminotomy/foraminotomy decompression of the nerve root and the July 28, 2015 cervical C6-7 laminotomy/foraminotomy decompression of the nerve root, performed at the Laser Spine Institute, were reasonable and necessary to cure or relieve the effects of the work-related accident. I would rely on the medical opinions of Petitioner's three treating neurosurgeons and vacate the award of medical expenses for those two surgeries.

Petitioner received extensive medical treatment following her September 16, 2010 work-related motor vehicle accident. Petitioner underwent an ACDF at 2 levels in November 2011 performed by Dr. Deutsch, a neurosurgeon. On July 27, 2012, Dr. Deutsch noted Petitioner was 10 months post cervical surgery and she had cervical spinal stenosis, back pain and neck pain. Dr. Deutsch stated that Petitioner's chance of improvement with additional surgery was very low and he found Petitioner to be at MMI. (PX 9)

Dr. Deutsch saw Petitioner again on October 19, 2012, and rendered the same assessment. He again stated *no* further surgery would help Petitioner. (PX9) Petitioner was seen by Dr. Amine on November 20, 2012, and he indicated Petitioner was at her base level of pain. Petitioner received a cervical ESI and bilateral facet injections on December 20, 2012. (PX13) Dr. Deutsch saw Petitioner January 14, 2013, and his assessment remained the same. Dr. Deutsch again stated Petitioner was at MMI and that Petitioner would *not* benefit from additional physical therapy or surgery. (PX 9)

Petitioner underwent a cervical MRI scan on April 23, 2013, and a cervical CT scan on April 23, 2013. The CT scan showed re-demonstrated changes of anterior cervical discectomy and fusion of C4 to C6, a solid interbody fusion across the C4-C5 and C5-C6 discs. (PX 9) Petitioner

was seen for follow up by Dr. Amine on May 9, 2013, and he noted the MRI showed solid fusion. (PX12)

Petitioner underwent a CT discogram on August 1, 2013 (PX 11, 12), and followed up with Dr. Amine on August 13, 2013, who found the discogram inconclusive. He stated Petitioner was definitely *not* a candidate for any further surgical intervention. (PX12) Dr. Amine saw Petitioner for follow up October 1, 2013, and again noted that on the basis of the discogram, he did *not* think Petitioner was a surgical candidate. (PX12) Dr. Amine saw Petitioner October 29, 2013, and again advised Petitioner she was *definitely not* a candidate for cervical spine intervention. (PX12) Dr. Amine saw Petitioner for a follow up on July 10, 2014. Dr. Amine noted that Petitioner was "begging him" for surgery and he again advised Petitioner as far as he was concerned, she was *not* a candidate for any surgery. (PX12)

On October 30, 2014, Petitioner presented to Dr. Schaible. Dr. Schaible noted that despite the cervical fusion, she failed to get or derive any clear improvement from her symptoms. Dr. Schaible noted Petitioner had treated with two other neurosurgeons before him. He noted Petitioner displayed no neurologic abnormalities on physical exam. In his assessment he advised Petitioner he doubted that he had anything to offer her. (PX16) On November 20, 2014, Dr. Schaible saw Petitioner for follow up and he noted he reviewed Petitioner's new MRI scans of the cervical and lumbar spine. He indicated the lumbar scan looked clean and he saw no evidence of disc herniation. He again advised Petitioner that he did *not* see there was any role for surgery. (PX16)

Despite the three unequivocal opinions from her treating neurosurgeons, Petitioner chose to treat at the Laser Spine Institute in Cincinnati, Ohio after seeing a television commercial advertisement. On July 21, 2015, Petitioner was seen by Dr. Kakarlapudi at the Laser Spine Institute and on July 22, 2015, Dr. Kakarlapudi performed a left L4-L5 laminotomy/foraminotomy decompression of the nerve root; destruction via thermal ablation of the paravertebral facet joints, right L4-L5, bilateral L5-S1. (PX 3, PX17)

The following day, on July 23, 2015, Petitioner was seen by Dr. Francavilla at the Laser Spine Institute. On July 28, 2015, Dr. Francavilla performed cervical selective nerve root block at right C7 and performed a right C6-C7 laminotomy/foraminotomy decompression of the nerve root; left C6-C7 destruction via thermal ablation of the paravertebral facet joint. (PX17)

On January 14, 2016, Petitioner returned to see Dr. Amine who noted that after the last visit in July, Petitioner was attracted by the commercial for laser spine surgery in Cincinnati and Petitioner went there and ultimately had cervical spine surgery and lumbar spine surgery. Dr. Amine noted that on July 22, 2015, Petitioner underwent an L4-5 discectomy and foraminotomy and on July 28, 2015, she underwent a posterior cervical unilateral C6-7 decompression. Dr. Amine noted Petitioner had spent a couple weeks there and $50,000 to return with the *same pain* in the same distribution. Dr. Amine noted Petitioner continued to have the pain in the cervical as well as the lumbar spine. (PX12)

Section 8(a) of the Act governs the award of medical care. That provision states in relevant part: "The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2 [(820 ILCS 305/8.2 (West 2012))], in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury…" 820 ILCS 305/8(a) (West 2012).

A claimant bears the burden of proving, by a preponderance of the evidence, his entitlement to an award of medical expenses under Section 8(a) of the Act. *Westin Hotel v. Industrial Comm'n*,

372 Ill. App. 3d 527, 546 (2007). That is, the 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 claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n of Ill*., 325 Ill. App. 3d 527, 758 N.E.2d 18, 2001 Ill. App. LEXIS 727, 259 Ill. Dec. 173 (2001). Questions as to the reasonableness of medical charges, the necessity of the medical services provided, and the causal relationship between the medical services and the work-related injury are questions of fact to be resolved by the Commission. *Shafer v. Illinois Workers' Compensation Comm'n,* 2011 IL App (4th) 100505WC, 51; *Max Shepard, Inc. v. Industrial Comm'n*, 348 Ill. App. 3d 893, 903 (2004).

In reviewing the totality of the record, and specifically the opinions of Dr. Deutsch, Dr. Amine and Dr. Schaible, Petitioner's treating neurosurgeons, Petitioner has failed to prove the July 2015 surgeries at the Laser Spine Institute were reasonable and necessary to cure or relieve from the effects of the work-related injury. During the time period from 2012 to 2014, three neurosurgeons stated multiple times that further surgery would not be beneficial. The final Dr. Amine visit of January 14, 2016, showed that Petitioner had indeed received no relief from those 2015 surgeries as she continued to have the same pain in her cervical and lumbar spine, and proved the three neurosurgeons were correct in their assessments that further surgery would be ineffective.

I would afford these opinions significant weight and find that Petitioner failed to meet the burden of proving the July 2015 surgeries at the Laser Spine Institute were reasonable and necessary as required under Section 8(a) and reverse the award of medical expenses for those surgeries. For this reason, I dissent.

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

21IWCC0419

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NELSON, MICHELLE Case# **10WC039701**

Employee/Petitioner

CHICAGO PUBLIC SCHOOLS

Employer/Respondent

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

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

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

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

0559 CHICAGO BOARD OF EDUCATION
KATHLEEN ULBERT
10 N DEARBORN ST SUITE 900
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

Michelle Nelson
Employee/Petitioner

v.

Chicago Public Schools
Employer/Respondent

Case # **10** WC **39701**

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 **Elaine Llerena**, Arbitrator of the Commission, in the city of **Chicago**, on **February 20, 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 **September 16, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**100,488.39**; the average weekly wage was $**1,932.47**.

On the date of accident, Petitioner was **47** 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 $**44,278.12** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**44,278.12**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $391,296.28, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,243.00 (the statutory maximum rate in effect on the date of the accident) per week for 426-6/7 weeks, commencing September 17, 2010 through April 19, 2015 and from December 18, 2015 through July 23, 2019, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $44,278.12 for TTD paid by Respondent.

Respondent shall pay Petitioner permanent and total disability benefits of $1,243.00 per week for life, commencing July 23, 2019, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

April 29, 2020
Date

APR 30 2020

STATEMENT OF FACTS:

At hearing, the parties stipulated to the submission of a medical chronology due to the age and volume of medical treatment in this matter. (JX1)

Petitioner was 47 years old and a Work Experience and Career Exploration Teacher/Coordinator for Respondent Chicago Public Schools on September 16, 2010. (AX1; T. 11) She had worked for Respondent for approximately 10 years. (T. 48-49) Her job responsibilities involved teaching students job placement skills and computers, as well as traveling to build partnerships within the community and outside the community, depending on where the students lived. (T. 11) Petitioner would travel for work using a motor vehicle. (T. 11-12)

Prior to September 16, 2010, Petitioner had been treated for a condition in her right foot. (T. 14) She had also complained of back pain from 2009 through May of 2010, which she treated with her primary care physician Dr. Cedric Coleman. (T. 14)

On September 16, 2010, Petitioner was traveling to a business partner for the purpose of trying to establish the placement of students for the new school year. (T. 12) As she reached Avenue O in Chicago, Petitioner came to a complete stop, and as she proceeded into the intersection, Petitioner was involved in a collision with another vehicle that had failed to make a complete stop. (PX22, T. 12) It was a heavy collision with significant front-end damage to her car and side impact damage to the other vehicle. (T. 13) Upon impact, Petitioner's airbag deployed, and her right foot slipped off the brake and struck the floorboard, twisting as it did so. (PX5 & PX22) Following the accident, Petitioner felt pain in her neck, lower back, right foot, head, and right shoulder. (T. 15)

Petitioner was transported via ambulance to Advocate Trinity Hospital. (T. 13) At the hospital, Petitioner reported back pain and difficulty walking, but no loss of consciousness. (PX2) Petitioner was diagnosed with a back sprain and cervical spine injury secondary to motor vehicle accident. *Id.* She was discharged with prescriptions for Hydrocodone and ibuprofen and was told to follow up with her primary care physician. (PX2, T. 14-15)

On September 20, 2010, Petitioner saw Dr. Paul Martin for continued treatment of existing bilateral foot tendinitis and Dr. Harold Pye, referred by Dr. Coleman. (PX3, T. 15-16) Dr. Martin put Petitioner in a fiberglass cast to immobilize her right lower extremity. (PX5, T. 15) Dr. Pye noted tenderness over Petitioner's posterior cervical musculature as well as tenderness over both trapezius muscles without spasm or limited range of motion. (PX4) Dr. Pye opined that Petitioner was temporarily totally disabled and took her off work. *Id.* He instructed her to follow up in 2-3 days and ordered x-rays of her knees and lumbar spine. *Id.*

On September 22, 2010, Petitioner returned to Dr. Pye complaining of neck, back, groin, and bilateral knee discomfort and continued headaches. *Id.* Examination of the cervical spine revealed pain with flexion, extension and lateral flexion. *Id.* Thoraco-lumbar spine examination revealed diffuse paralumbar spasm to palpation. *Id.* Dr. Pye noted right knee tenderness over the MCL and LCL ligaments, with mild anterior swelling, left knee tenderness over the MCL and LCL, with slightly limited range of motion secondary to discomfort and right groin tenderness with palpation. *Id.* Dr. Pye diagnosed Petitioner as having post-concussion syndrome, meniscal derangement, patellar chondromalacia, and neck, thoracic, lumbar, and coccyx sprains/strains as well as bilateral sprains/strains of the knee ligaments and ankles. *Id.* Dr. Pye prescribed Petitioner Celebrex, Traumanil gel, Tramadol, Omeprazole, Lidoderm patches and physical therapy. *Id.* He also ordered MRIs of Petitioner's brain, lumbar spine and lower extremities. *Id.*

On September 28, 2010, Dr. Coleman ordered Petitioner a rollabout knee walker and diagnosed her with tendinitis tibialis ankle tarsus. (PX3) That same day, Petitioner began physical therapy at HTP Associates, which she would undergo through June 4, 2013. (PX4)

Petitioner continued to follow up with Dr. Pye, complaining of continued neck and back pain without improvement, pain in her right shoulder localized to the anterior A/C joint and slight improvements in her headaches and bilateral groin and knee pain. *Id.*

On October 27, 2010, Petitioner underwent MRIs of her right knee, brain, and lumbar spine at AMIC. *Id.* The results of the right knee and lumbar MRIs were normal, while her brain MRI revealed mucosal changes of chronic sinusitis but was negative for findings indicative of acute injury. *Id.*

On December 10, 2010, Petitioner followed up with Dr. Martin for her right foot posterior tibial tendinitis. (PX5) Petitioner reminded Dr. Martin that she had been in a motor vehicle accident on September 16, 2010 and reported that upon impact, her right foot slipped off the brake and twisted as it struck the floorboard. *Id.* Dr. Martin noted that he recalled her reporting this accident to him earlier in the fall. *Id.* Dr. Martin opined that although Petitioner had preexisting tendinitis, her motor vehicle accident aggravated her condition. *Id.*

Petitioner also returned to Dr. Pye on December 10, 2010. (PX4) She had undergone physical therapy and was using a personal transport cart to get around. *Id.* Dr. Pye reviewed Petitioner's MRI results and diagnosed Petitioner with cervical spinal stenosis and lumbosacral sprain/strain. *Id.*

Petitioner continued to treat with Dr. Martin and Dr. Pye for her various conditions. (PX4 & PX5, T. 16-17) On January 5, 2011, Petitioner reported to Dr. Pye that she was continuing to experience chronic headaches, as well as short-term memory loss post-accident. (PX5) Dr. Pye referred Petitioner to University Neurologists at Rush, where she would treat with Dr. Lakshmi Warrior. (PX5, T. 17) He also referred Petitioner to Dr. Charles Slack for her spine condition, Dr. Lee for foot and ankle treatment, and Dr. Neeraj Jain for pain management. (PX4)

On January 28, 2011, Petitioner saw Dr. Warrior and reported that she had been experiencing mild headaches two to three times a week since the accident and twice-monthly severe headaches with throbbing, nausea, vomiting, photophobia, phonophobia, and dark spots in her vision. (PX6) Petitioner also related that she had been experiencing memory loss since the accident. *Id.* She couldn't remember her head trauma, had been getting lost after receiving directions and accidentally leaving food on the stove. *Id.* Petitioner also reported she was behind on her bills. *Id.* Petitioner had once been highly organized but was now afraid she would forget her lectures if she returned to work. *Id.* Dr. Warrior performed a mini mental status exam and Petitioner scored 27/30 with symptoms consistent with post-concussive syndrome. *Id.* Dr. Warrior recommended a head CT scan to rule out chronic subdural hematoma and a brain MRI to evaluate her memory loss and headaches. *Id.*

Petitioner underwent a non-contrast brain CT on January 31, 2011, the results of which revealed small radio opaque calcifications in her left parietal scalp but was otherwise normal. *Id.*

On February 21, 2011, Dr. Martin discussed surgical options with Petitioner and Petitioner indicated that she wished to exhaust her conservative options first. (PX5) Dr. Martin kept Petitioner off work and instructed her to follow up in two months. *Id.*

On February 23, 2011, Dr. Coleman authored a statement of medical necessity for Petitioner's rollabout knee walker. (PX3)

On April 6, 2011, Petitioner underwent a neuropsychological exam with Dr. Bryan Bernard, to whom Petitioner was referred to by Dr. Warrior. (PX6) Petitioner scored 25/30 on the mini mental state exam administered by Dr. Bernard and was found to have impaired attention and language, as well as borderline verbal intellectual skills, low average non-verbal skills, and variable recent memory. *Id.*

On May 19, 2011, Petitioner, at Respondent's request, underwent an independent medical examination (IME) with Dr. George B. Holmes focused on her feet and ankles. (RX1) Dr. Holmes opined that he could not determine any objective basis for Petitioner's conditions and that they were probably not related to her motor vehicle accident. *Id.* He recommended that she undergo a functional capacity evaluation to determine if she could return to work. *Id.*

Later that same day, Petitioner underwent another IME, this time with Dr. Gunnar Andersson, for her back and neck. *Id.* Dr. Andersson opined that Petitioner may have strained her neck and back during her motor vehicle accident, but that there was no evidence in her MRIs of any significant underlying condition of the spine. *Id.* Dr. Andersson found that Petitioner had reached maximum medical improvement (MMI) for her neck and back and that she could return to work with restrictions of 20 pounds lifting occasionally and 10 pounds lifting repetitively for 4-6 weeks. *Id.* Dr. Andersson stated that he had nothing to add to Dr. Holmes's findings with regard to Petitioner's foot and ankle problems. *Id.*

Petitioner continued to treat with Dr. Coleman, Dr. Martin, and Dr. Pye. (PX3, PX4 & PX5) A June 2, 2011 MRI of Petitioner's right ankle and mid-foot showed soft tissue edema within the circumference of the right ankle to forefoot and including Kager's triangle, tenosynovitis of the posterior tibial tendon with what appeared to be chronic tendinosis at the navicular insertion and early osteoarthritic changes of the tibiotalar joint and subtalar joints. (PX5)

On June 13, 2011, Dr. Martin opined that Petitioner remained unable to work and Petitioner agreed to undergo surgical correction of the deformity in her right foot. (PX5) On follow-up on June 17, 2011, Dr. Martin opined that although Petitioner had a preexisting right foot condition, that condition got significantly worse after her work accident. *Id.*

On July 7, 2011, Dr. Martin performed a flat foot reconstruction of Petitioner's right foot at Rush Oak Park Hospital. (PX3)

On July 14, 2011, Petitioner underwent a lumbar spine MRI which showed early lower lumbar degenerative disease. (PX4)

On July 15, 2011, Petitioner returned to Dr. Martin in a cast brace for follow-up. (PX5) Dr. Martin opined that Petitioner's work accident likely triggered and accelerated the process that led to her developing a flat foot deformity in her right foot. *Id.*

Petitioner continued to follow up with Dr. Pye and Dr. Warrior. (PX4 & PX6) On August 3, 2011, Petitioner returned to Dr. Warrior reporting continued headaches, foot pain, and back pain with pins-and-needles sensations down both legs and an increased urge to urinate. (PX6) Petitioner reported that she was experiencing headaches with a migraine quality 3-4 times per day, but her memory difficulties had greatly improved. *Id.* She further reported that she was strongly considering going back to work for the next school year. *Id.* Dr. Warrior had Petitioner continue physical therapy and counseling with Dr. Bernard for her memory and prescribed a nightly amitriptyline regimen. (PX6)

On August 16, 2011, Petitioner underwent a functional capacity evaluation (FCE) at US Rehabilitation Services, the results of which determined that Petitioner demonstrated consistent effort with majority reliable pain ratings and was able to perform 82.5% of the physical demands of a teacher and was able to perform at a sedentary physical demand level. (PX4)

On September 30, 2011, University Neurologists at Rush referred Petitioner to Dr. Harel Deutsch at Rush University Neurosurgery Division after a lump was found on her spine. (PX8 & PX9, T. 18-19) Dr. Deutsch took over care for Petitioner's neck problems. (PX8 & PX9, T. 19) At her initial visit with Dr. Deutsch, Petitioner could not remember when her symptoms started, and she denied headaches or memory loss. (PX8 & PX9) Dr. Deutsch reviewed Petitioner's diagnostic studies and found they showed cervical spinal stenosis from multiple disc bulges at C4-5 and C5-6, and to a lesser extent at C3-4. *Id.* Dr. Deutsch opined that these bulges were the cause of her symptoms and not the lump. *Id.*

On October 25, 2011, Dr. Coleman diagnosed Petitioner as having cervical radiculopathy. (PX3)

On November 8, 2011, Dr. Deutsch performed an anterior cervical discectomy and fusion on Petitioner at C4-5 and C5-6 with allograft instrumentation. (PX3 & PX9, T. 20)

Petitioner testified that post-surgery she continued to see Dr. Martin for her right foot and ankle and continued to treat with Dr. Deutsch, Dr. Pye, and Dr. Coleman into and beyond March 2012. (T. 20-21) Petitioner continued to complain of headaches and right shoulder pain. (T. 21)

On May 14, 2012, Dr. Richard Brash, whom Petitioner had been referred to by Dr. Pye for consultation regarding her right shoulder impingement, performed an arthroscopic procedure on Petitioner's right shoulder. (PX4 & PX7) He debrided the rotator cuff, excised a spur in her right shoulder, and performed lysis of subacromial adhesions. (PX7)

On July 27, 2012, Dr. Deutsch opined that Petitioner had reached MMI for her neck condition, as she hadn't been improving in terms of neck pain and the odds of improvement with further surgery were low. (PX8) However, on October 19, 2012, Petitioner returned to Dr. Deutsch once more for her continuing neck pain. *Id.*

In November 2012, Petitioner returned to University Neurologists at Rush, where she came under the care of Dr. Matthew Raday. (PX6, T. 23) Petitioner testified that she was referred to Rush Pain Center, where she was evaluated for pain management. (PX13, T. 23) Petitioner saw Dr. S. Amin, who administered a course of cervical epidural steroid injections. (PX13)

Sometime in 2012, Respondent fired Petitioner for the stated reason of lying about her residence address. (T. 50) Petitioner had represented to Respondent that she lived on Artesian Avenue in Chicago; Petitioner did own a residence on Artesian Avenue in Chicago, but also owned a second residence in South Holland. (T. 51) At times, she had resided at each property. (T. 51) During those times, Petitioner was going through a divorce with her husband and they lived separately. (T. 52)

On January 14, 2013, Dr. Deutsch opined that Petitioner was at MMI, that she was unlikely to benefit from further physical therapy or surgery and that she could not work. (PX3 & PX9)

Dr. Pye then referred Petitioner to Dr. Abdul Amine, a neurosurgeon, for a second opinion. (PX4 & PX12) On March 5, 2013, Dr. Amine diagnosed Petitioner as having chronic cervical radiculopathy. (PX12) Petitioner continued to treat with Dr. Amine and with Rush University Medical Center over the coming months,

during which time Dr. Amine referred Petitioner to pain management physician Dr. Ebby Jido. (PX12, T. 25-26)

On June 4, 2013, Petitioner underwent an FCE at US Rehabilitation Services. (PX4) The FCE determined that Petitioner was able to perform 90% of the physical demands of a teacher and demonstrated the ability to perform at a light physical demand level. *Id.* Pain was noted to be a limiting factor. *Id.*

On August 1, 2013, Petitioner underwent a discogram procedure performed by Dr. Jido at Advocate Christ Hospital. (PX11 & PX12) The results were positive at C2-3, C3-4, and C6-7, but C2-3 was most notable with severe pain. *Id.*

On October 6, 2013, Dr. Amine opined that Petitioner was not able to work full capacity and that she would probably require continuous medical treatment and pain management. (PX12) On October 13, 2013, Dr. Amine reviewed the discogram results and opined that the procedure was inconclusive since pain was concordant at all levels except for C7-T1. *Id.* He opined that Petitioner was not a candidate for further surgical intervention. *Id.*

On October 8, 2013, Petitioner returned to DuPage Medical Group. (PX7, T. 27) Dr. Brash had retired, so Petitioner's care was taken over by Dr. Daryl O'Connor. *Id.* Petitioner related her history of injury, complaining of right shoulder pain since her car accident on September 16, 2010. (PX7) Petitioner complained of pain with overhead motions, as well as popping and grinding in her shoulder. *Id.* On examination, her shoulder was tender to palpation, particularly over the biceps, with positive Neer and Hawkins impingement signs. *Id.* Dr. O'Connor opined that Petitioner's symptoms were consistent with rotator cuff tendinitis and a possible full-thickness tear of the tendon. *Id.* Dr. O'Connor opined that Petitioner's current symptoms were related to her work accident. *Id.*

On October 29, 2013, Petitioner returned to Dr. Amine, who reiterated his opinion that Petitioner was not able to work full capacity and that she would probably require continuous medical treatment and pain management. (PX12) He advised her to return to Dr. Jido. *Id.*

Petitioner continued to treat with Dr. Amine, Dr. O'Connor, and Dr. Jido into 2014. (PX7 & PX10, T. 27-28)

On April 24, 2014, Petitioner saw Dr. Bernard who performed a cognitive evaluation and noted that Petitioner's results were lower on measures of verbal memory compared to her exam three years ago. (PX6) Test results also revealed impairment in executive function, language and visual perception. *Id.* Dr. Bernard also noted that Petitioner performed low on the measure of effort and that Petitioner appeared more depressed and had problems with anxiety. *Id.* Dr. Bernard recommended psychiatric consultation. *Id.*

On July 10, 2014, Petitioner was seen by Dr. Megan Shanks at the Rush Department for Neurological Sciences. (PX6) Dr. Shanks noted that Petitioner's muscle tension neck pain and headaches were better overall. *Id.*

Petitioner continued her treatment through the summer and fall of 2014 with Dr. Jido and Dr. Martin. (PX5 & PX10, T. 30) On July 25, 2014, Dr. Martin fitted Petitioner with an orthotic for her foot. (PX5) Petitioner reported little immediate change in her pain level. *Id.* He instructed her to return in 6 weeks. *Id.* On September 5, 2014, Petitioner returned to Dr. Martin reporting that her foot and ankle pain had improved but not completely resolved. *Id.* Dr. Martin started her on Naproxen and modified her orthotics. *Id.*

On September 11, 2014, a Sedgwick Utilization Review certified the use of a spinal cord stimulator. (PX11) On October 9, 2014, Dr. Jido implanted a temporary lead for a spinal cord stimulator on a trial basis. (PX11 & PX20) On October 13, 2014, Dr. Jido removed the lead. *Id.* Petitioner returned to Dr. Jido on October 22, 2014, at which time Dr. Jido noted Petitioner was not a good candidate for a permanent lead and referred Petitioner to Dr. Keith Schaible for a second opinion. (PX10, PX11 & PX20)

Petitioner saw Dr. Schaible on October 30, 2013. (PX16) Dr. Schaible noted that physical examination revealed no neurologic abnormalities. *Id.* Dr. Schaible indicated that he doubted he could offer her anything. *Id.* Afterwards, she continued to treat with Dr. Jido. (T. 31)

Throughout early 2015, Petitioner continued her treatment with Dr. Coleman. (PX3, T. 32)

In mid-to-late April 2015, Petitioner returned to work for Respondent as a computer teacher. (T. 55-56) Petitioner then sought treatment at the Laser Spine Institute on her own, making her second independent choice of physician. (PX17, T. 32) Petitioner began treating there on an ongoing basis. *Id.* Petitioner went on summer break from work in June. (T. 56)

On July 22, 2015, Petitioner underwent a laminotomy, foraminotomy, and decompression of the nerve root at L4-5 and L5-S1 at the Laser Spine Institute. (PX17) Post-operatively, Dr. Thomas Francavilla of the Laser Spine Institute diagnosed Petitioner as having stenosis at L4-5. (PX17) On July 28, 2015, Dr. Francavilla performed a right C6-7 laminectomy/foraminotomy decompression of the nerve root, as well as tri-thermal ablation of the facet joint at C6-7. *Id.*

Petitioner resumed work with the new school year in September. (T 56.) Petitioner continued to treat with Dr. Coleman and the Laser Spine Institute through to November 2015. (PX3 & PX17, T. 33)

On November 17, 2015, Petitioner underwent physical therapy and occupational therapy evaluations at Sport and Ortho Physical Therapy. (PX18) The evaluators noted that Petitioner had been allowed to teach from her seat, but that work was getting hard for her due to stiffness. *Id.*

A lumbar MRI taken on November 30, 2015 at Advocate Christ Medical Center revealed post-operative changes at left L4-5 laminectomy defect. (PX11)

In December 2015, Respondent informed Petitioner that she was not performing well. (T.56) As a result, Petitioner stopped working. *Id.*

Petitioner continued to treat with Advocate Medical Group and Dr. Jido with continued complaints of chronic neck and back pain with lower extremity radiculopathy. (PX10)

On April 13, 2016, Dr. Jido and Dr. Amine performed a procedure to insert a morphine pump implant. (PX20) However, the implant became infected with MRSA and on May 16, 2016, it was removed. *Id.*

Petitioner continued to treat with Dr. Coleman, Advocate Medical Group, and Advocate Hospital through the rest of 2016 and into the fall of 2017. (T 35.) On September 26, 2017, Dr. Coleman referred Petitioner to podiatrist Dr. Carlos Smith for another opinion regarding her ongoing heel pain. (PX3 & PX20, T. 35)

Petitioner continued to treat with Advocate Medical Group through the rest of 2017 and into the fall of 2018. (PX20, T. 36) Petitioner also continued to receive injections from Dr. Jido. (PX10, T. 36)

A thoracic spine MRI taken on March 12, 2018 revealed multiple degenerative disc changes predominantly at T4-5 and T7-8 resulting in right-sided subarticular zone effacement and mild right-sided foraminal narrowing. (PX2 & PX11) An MRI of the cervical spine performed on April 20, 2018 showed chronic surgical changes at C4-6 with interval surgical of right C6 laminectomy. (PX2) Petitioner also underwent a CT scan of the cervical spine on May 10, 2018, the results of which showed mild concentric stenosis and mild left-sided neural foraminal encroachment at C3-4 due to degenerative spondylosis, mild neural foraminal encroachment at C6-7 due to degenerative spondylosis, post-surgical anterior fusion at C4-5 and C5-6 and small subpleural cysts and minimal linear fibrosis at the left and right lung apex. *Id.*

On May 24, 2018, physician's assistant Alexandra Venetos at Advocate Medical Group diagnosed Petitioner as having neuralgia and failed back syndrome. (PX20) Venetos recommended that Petitioner return to pain management to determine if she was a candidate for further conservative therapy or for a spinal cord stimulator. *Id.*

Dr. Coleman referred Petitioner to Dr. Anil Gulati at Advocate Trinity Hospital for a second opinion regarding her continuing pain, whom Petitioner saw on September 10, 2018. (PX3 & PX19, T. 36-37) Dr. Gulati ordered an EMG, discontinued Petitioner's Flexeril, increased her Cymbalta, continued her Gabapentin and added Baclofen, Clonazepam and Ditropan. (PX19)

On December 13, 2018, Petitioner underwent a cervical MRI, the results of which showed mild concentric stenosis and mild bilateral neural foraminal encroachment at C3-4 due to degenerative spondylosis, mild concentric stenosis and left-sided neural foraminal encroachment at C6-7 due to degenerative spondylosis and post-surgical anterior fusion at C4-5 and C5-6. (PX20)

Petitioner continued to treat with Dr. Gulati and Dr. Jido through 2019. (PX10 & PX19, T. 37-38) Dr. Jido performed additional epidural steroid injections to manage Petitioner's pain. (PX10)

On April 5, 2019, Petitioner underwent an MRI of the thoracic and lumbar spine which showed degenerative spondylosis visualized from T3-4 to T9-10, as well as facet degenerative changes at L4-5 and L5-S1. (PX19 & PX20)

On April 19, 2019, Dr. Gulati noted mild upper extremity weakness and much greater weakness in the lower extremities on examination and indicated that Petitioner had a markedly impaired gait. (PX19) Dr. Gulati diagnosed Petitioner as having cervical and back pain with associated leg pain and ataxia, as well as mild quadriparesis and pronounced gait disturbance. *Id.* He stated that Petitioner's history of muscle spasms in the lower extremities, her fluctuating weakness in all extremities, greater in the lower extremities, and her history of bladder incontinence all suggested cervical myelopathy. *Id.* Petitioner continued to treat with Dr. Gulati throughout 2019 and into 2020. (PX19, T. 40)

On July 23, 2019, Petitioner, at the request of her attorney, saw Dr. Howard Freedberg for an IME. (PX22) Petitioner described the September 16, 2010 work accident and Dr. Freedberg examined Petitioner and reviewed her medical records and diagnostic exams. *Id.* He noted a pre-accident MRI of the lumbar spine from May 28, 2010 showed facet arthropathy at L4-L5 and L5-S1 with no herniations. *Id.* Dr. Freedberg took x-rays of Petitioner's lumbar, thoracic, and cervical spine and found that Petitioner had severe degenerative changes of the cervical spine at C3-C4 and C6-C7 with anterior decompression and plating and screws at C4 to C6 which were intact and healed. *Id.* Dr. Freedberg diagnosed Petitioner as having lumbar neuritis, radiculitis and cervicalgia and that she was status post C4 to C6 ACDF with thoracic pain. *Id.* Dr. Freedberg found that Petitioner had marked limitations and felt that her clinical conditions of ill-being were directly causally

connected to the September 16, 2010 motor vehicle accident. *Id.* Dr. Freedberg noted that prior to the accident Petitioner was functional and was able to perform activities of daily living. *Id.* Dr. Freedberg stated that the accident produced a cascade of events which produced significant difficulties and inability to function for Petitioner. *Id.* He opined that there was no chance that Petitioner was ever going to return to the workforce. *Id.* He noted that Petitioner had an ataxic gait and was completely dependent on a walker. *Id.* Dr. Freedberg determined that Petitioner was at MMI, had completed treatment and was completely impaired from ever returning to work. *Id.*

On August 26, 2019, vocational rehabilitation counselor Susan A. Entenberg completed a vocational rehabilitation evaluation of the Petitioner at the request of Petitioner's attorney. (PX21) Entenberg opined that Petitioner was not capable of returning to her past work as a teacher, was not a good candidate for vocational rehabilitation and that a stable labor market did not exist for her. *Id.* Entenberg opined that no stable labor market existed for Petitioner due to her age at the time of 56, the fact that Petitioner had had no sustained work activity for the previous 9 years, her very limited physical tolerances and complete dependence on a walker, her cognitive difficulties and the determination that she was unable to work by both treating and examining physicians. *Id.* Entenberg further opined that Petitioner was not a good candidate for vocational rehabilitation after weighing the following factors: (1-2) Petitioner suffered reduced earning power and job security following her work accident due to her limitations and the nature of her job; (3) there was no prior vocational rehabilitation; (4) Petitioner would not be an appropriate training candidate based on her restrictions; (5) Petitioner's past job contained transferable skills relating to educational development, technique and computer technology; (6A) Petitioner had a work-life expectancy of only 11 years; (6B) Petitioner had cooperated in treatment and attempted to return to work on two occasions but was unable to sustain the work activities; and (6C) Petitioner had permanent restrictions not susceptible to recovery through medical rehabilitation. *Id.*

On October 1, 2019, Petitioner underwent an IME with Dr. Michael Lewis at Respondent's request. (RX1) Dr. Lewis examined Petitioner and reviewed her medical records and diagnostic exams. *Id.* Dr. Lewis indicated that although he was unable to find objective evidence of pathology in Petitioner's thoracic spine and was unable to examine Petitioner's right foot and ankle due to her refusal to allow examination of her right foot and ankle, he nonetheless agreed with Dr. Freedberg and Entenberg that Petitioner is unable to return to the workforce. *Id.* Dr. Lewis opined that there is a causal relationship between Petitioner's current complaints and her work accident of September 16, 2010. *Id.* Dr. Lewis stated that due to Petitioner's walker dependence and inability to raise her right arm above shoulder level, any work she did perform would necessarily be sedentary and not involve overhead use of the right upper extremity. *Id.* Dr. Lewis agreed with Dr. Freedberg regarding the fact that Petitioner was at MMI and recommended no additional treatment. *Id.*

At hearing, Petitioner testified that she continues to have pain in her back, buttock, foot, neck and shoulders. (T. 42-43) She testified that she was experiencing pain sitting in the chair during the arbitration hearing. (T. 43) She explained that she takes a lot of medications and cannot sleep the full night through without waking up. (T. 46) Petitioner testified that she can sit for less than 30 minutes at a time without having to get up. (T. 44) Petitioner can stand, but only with support and relies on her walker for support. (T. 44-45) Petitioner can bend only a little bit and cannot lift more than one to two pounds. (T. 45)

Petitioner testified that she requires that her son live with her. (T. 41) She explained that when she gets up in the morning, she is unable to get out of bed by herself and has to call her son to come help her. (T. 41) Petitioner testified that he cups one hand behind her neck and pulls her up by the hand with his other hand. (T. 41-42) She then takes a few minutes to get moving. (T.42) Oftentimes, Petitioner cannot make it to the bathroom quickly enough and wets herself. *Id.* Petitioner relies on her son to help her with getting dressed, cooking and navigating the stairs. (T. 42) Most of the time, she stays upstairs because once she is up there it is hard for her to come back down. (T. 42)

Petitioner testified that she tried to drive but had blurry vision and experienced the sensation of moving even when at rest, causing her to press down on the pedals too hard. (T. 45-46) Therefore, she has to have someone else drive her places. (T. 46)

Petitioner testified that she spent three years bedridden and that Dr. Gulati is responsible for getting her an upright walker and getting her walking again. (T. 43) Petitioner continues to treat with Dr. Gulati for pain management and for issues controlling her bladder. (T. 40-41) She goes to physical therapy about three days per week. (T 49.) Petitioner's pain management consists primarily of medications. (T. 55) She also gets a Toradol shot from Dr. Coleman approximately once every two weeks. (T. 55)

Petitioner testified that she remains unclear on whether she is retired following her leaving work in December 2015 or whether she is still technically an employee. (T. 56-57)

At the time of her injury, Petitioner was married with no dependent children. (AX1) Petitioner has $380,852.77 in unpaid, outstanding medical bills, $639.51 in out-of-pocket expenses and $9,804.00 in subrogration from Blue Cross/Blue Shield and First Recovery Group. (PX1.)

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

The parties agree that Petitioner suffered a work-related injury on September 16, 2010. (AX1) However, Respondent disputes that Petitioner's current condition of ill-being is causally related to her work injury. The Arbitrator addresses each condition in turn.

Head

As to Petitioner's head injury, Petitioner was diagnosed with post concussive syndrome following the work accident. On January 28, 2011, Petitioner was seen at Rush's neurological department and was diagnosed with post-concussive syndrome. On April 6, 2011, it was noted that her head trauma was relatively mild and that she should be referred for a psychiatric consult. The head MRI done on October 27, 20101 was negative for any acute pathology.

The Arbitrator finds that Petitioner suffered a mild concussion on September 16, 2010. The Arbitrator notes that Petitioner continues to have problems with blurry vision and experiences the sensation of moving even when at rest. As such, Petitioner does not drive. The Arbitrator further notes that the April 24, 2014 cognitive evaluation of Petitioner found reduced verbal memory and impairment in executive function, language and visual perception. Dr. Bernard also noted that Petitioner performed low on the measure of effort during the examination and that Petitioner appeared more depressed and had problems with anxiety. The Arbitrator notes that Petitioner did not have any of these problems prior to the work accident and was fully functional prior to the work accident.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being regarding her head injury is causally related to her work accident of September 16, 2010.

Right Foot and Ankle

The law in Illinois is that when a work accident aggravates a preexisting condition, causation is established. *See Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 215 (2003). In this case, Petitioner's testimony

establishes that prior to September 16, 2010, she had a preexisting right foot condition. However, she also testified that, as a result of the accident, her right foot slipped off the brake and struck the floorboard, twisting as it did so. Following the accident, Petitioner felt pain in her right foot. This unrebutted testimony is supported by the opinion of Dr. Martin who opined that although Petitioner had preexisting tendinitis, her motor vehicle accident had aggravated her condition.

The Arbitrator notes that Dr. Holmes opined that Petitioner's foot and ankle condition was not related to the accident. However, the Arbitrator further notes that Dr. Holmes basis for his opinion was his inability to determine any objective basis for Petitioner's foot condition. Given that Petitioner had preexisting tibial tendinitis even prior to the accident, it is odd that Dr. Holmes would be unable to find a basis for the condition after the accident. For this reason, the Arbitrator finds Dr. Martin more persuasive in this matter than Dr. Holmes.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being regarding her right foot and ankle is causally related to her work accident of September 16, 2010.

Cervical Spine

There is no record of any preexisting neck pain or injury prior to Petitioner's work accident of September 16, 2010. Following her accident, she felt neck pain, a symptom consistently reported in every medical record going forward and which she credibly testified to at hearing.

The Arbitrator notes that Dr. Freedberg opined Petitioner's cervical spine x-rays showed severe degenerative change of the cervical spine at C3-C4 and C6-C7 with anterior decompression and plating and screws at C4 to C6 which were intact and healed. Dr. Freedberg also opined that her conditions of ill being are directly causally related to the work accident. Dr. Freedberg noted that prior to the work accident, Petitioner was functional and able to perform activities of daily living. Dr. Freedberg further opined that the accident produced a cascade of events which produced significant difficulties and an inability to function.

Notably, Respondent's own IME, Dr. Lewis, agreed with Dr. Freedberg. Dr. Lewis opined that there is a causal relationship between Petitioner's current complaints and the work accident.

The Arbitrator note that Respondent's other IME, Dr. Andersson, opined back on 2011 that he back and neck problems Petitioner complained of occurred during the work accident. Dr. Andersson ultimately determined that Petitioner suffered a sprain/strain, did not require treatment and could return to work. The Arbitrator notes that these findings are inconsistent with Petitioner's subsequent development of myelopathic symptoms of ataxic gait and loss of bladder control and are not supported by subsequent medical records and diagnostic exams. For these reasons, the Arbitrator finds the opinions of Drs. Freedberg and Lewis more persuasive than those of Dr. Andersson.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being regarding her cervical spine is causally related to her work accident of September 16, 2010.

Lumbar Spine

Petitioner complained of back pain from 2009 through to May of 2010, for which she treated with Dr. Coleman. However, despite Petitioner's back pain, she was able to work full duty until the work accident. Dr. Freedberg opined that Petitioner suffered from lumbar neuritis and radiculitis directly causally related to the

work accident. The Arbitrator finds that prior to this accident Petitioner was functional and was able to perform her job and activities of daily living.

As with Petitioner's cervical spine condition, Dr. Lewis again agreed with Dr. Freedberg, opining that there is a causal relationship between Petitioner's current complaints and her accident of September 16, 2010.

Again, the only doctor to offer an opinion disputing causal connection was Dr. Andersson. However, he did so based on the medical evidence available in mid-2011. The Arbitrator notes that Dr. Freedberg and Dr. Lewis each had access to approximately eight more years of treatment records than Dr. Andersson did when drawing their conclusions in this case. Therefore, the Arbitrator finds them more persuasive in this matter than Dr. Andersson.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being regarding her lumbar spine is causally related to her work accident of September 16, 2010.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

The parties do not agree as to what were Petitioner's earnings during the year preceding the work accident. (AX1) However, neither party provided any evidence regarding Petitioner's earnings. At hearing, Respondent's counsel explained that the parties were waiting on wage records to verify Petitioner's earnings and determine her average weekly wage. (T. 4) Petitioner's counsel stipulated to any wage statement provided by Respondent from the funding program for Petitioner's position. (T. 4-5) Respondent indicated that Petitioner earned $100,488.39 in the year preceding the accident. As such, the Arbitrator finds that Petitioner's average weekly wage is $1,932.47.

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

The Arbitrator has reviewed the medical records and Petitioner's testimony and finds that Petitioner's medical services were reasonable and necessary. As such, the Arbitrator finds that Respondent is liable for the $380,852.77 in related medical bills that remain outstanding, $639.51 in out-of-pocket expenses and $9,804.00 in subrogration from Blue Cross/Blue Shield and First Recovery Group. (PX1)

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:

Respondent has paid temporary total disability benefits of $44,278.12, representing September 22, 2010 through May 27, 2011. Respondent terminated TTD payments based on the findings of Dr. Holmes and Dr. Andersson in their respective IMEs of May 19, 2011.

As discussed above, the Arbitrator does not find Dr. Holmes's opinions with respect to causal connection of Petitioner's foot and ankle conditions persuasive in this matter. Further, he issued no opinion at all with regard to whether Petitioner could return to work, instead deferring to the findings of a future functional capacity evaluation. Petitioner underwent a functional capacity evaluation approximately three months later on August 16, 2011, during which she demonstrated consistent effort and was able to perform 82.5% of the

physical demands of a teacher, demonstrating the ability to perform only at the sedentary physical demand level.

Similarly, Dr. Andersson's opinion that Petitioner could return to work was directly contradicted by Petitioner's subsequent functional capacity evaluation. The Arbitrator notes that even when Petitioner returned to work in 2015, it was Respondent who ultimately concluded that Petitioner could not perform her job.

As for Dr. Andersson's opinion that Petitioner reached MMI on May 19, 2011, he based this conclusion on the belief that her neck and back conditions were nothing more than sprains/strains. As discussed above, these diagnoses are not consistent with the medical evidence that came after. With the benefit of eight years' more evidence, Dr. Freedberg put Petitioner at MMI as of July 23, 2019, a conclusion that Dr. Lewis agreed with. Therefore, the Arbitrator adopts July 23, 2019 for Petitioner's MMI date

Petitioner was unable to work from September 17, 2010 to April 19, 2015 (239-2/7 weeks) and from December 18, 2015 through July 23, 2019 (187-4/7 weeks) totaling 426-6/7 weeks. Although Petitioner's average weekly wage is $1,932.47, two-thirds that amount exceeds the maximum TTD rate of $1,243.00 that was in effect on September 16, 2010. As such, the Arbitrator finds that Petitioner's TTD benefits owed total $529,873.50 (426-6/7 weeks x $1,243.00). Respondent shall be given a credit for all TTD paid on this claim.

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

"A person is totally disabled when he cannot perform any services except those which are so limited in quantity, dependability, or quality that there is no reasonably stable market for them." *South Motor Imports, Inc. v. Indus. Comm'n*, 52 Ill.2d 485, 489 (1972). "There are three ways that a claimant can establish permanent and total disability, namely: by a preponderance of medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of his age, training, education, experience, and condition, there are no jobs available for a person in his circumstances." *Fed. Marine Terminals, Inc. v. Illinois Workers' Comp. Comm'n*, 371 Ill. App. 3d 1117, 1129, 864 N.E.2d 838, 848 (1st Dist. 2007) A claimant who proves permanent and total disability via one of the latter two methods is referred to as an "odd lot" employee. *City of Chicago v. Illinois Workers' Comp. Comm'n*, 373 Ill. App. 3d 1080, 1091, 871 N.E.2d 765, 775 (1st Dist. 2007).

For the following reasons, the Arbitrator finds that Petitioner is totally disabled. First, the Arbitrator finds that "a preponderance of medical evidence" supports the conclusion that Petitioner cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable market for them. The medical evidence shows that Petitioner suffers from ataxia, upper extremity weakness, much greater weakness in the lower extremities, complete dependence on a walker, pronounced gait disturbance, constant pain, blurred vision, impaired memory and cognition, and incontinence. Dr. Freedberg opined that there was no chance that Petitioner was ever going to return to the workforce. He noted that Petitioner has an ataxic gait and is completely dependent on a walker. Dr. Freedberg opined that Petitioner had reached MMI as of July 23, 2019, had completed treatment, was impaired from returning to the workplace and that her conditions were permanent in nature. Dr. Lewis concurred with Dr. Freedberg's conclusions.

Second, in addition to proving total disability through the medical evidence, the Arbitrator finds that Petitioner has "demonstrated that because of her age, training, education, experience, and condition, there are no jobs available for a person in her circumstances." Vocational rehabilitation counselor Entenberg opined that Petitioner was not capable of returning to her past work as a teacher, that she was not a good candidate for vocational rehabilitation. She further found that a stable labor market did not exist for Petitioner due to her age of 56, the fact that Petitioner had no sustained work activity for the previous 9 years, her very limited physical

tolerances, her complete dependence on a walker, her cognitive difficulties and the determination that Petitioner was unable to work by both treating and examining physicians.

Entenberg further opined that Petitioner was not a good candidate for vocational rehabilitation after weighing the following factors: (1-2) Petitioner suffered reduced earning power and job security following her work accident due to her limitations and the nature of her job; (3) there was no prior vocational rehabilitation; (4) Petitioner would not be an appropriate training candidate based on her restrictions; (5) Petitioner's past job contained transferable skills relating to educational development, technique, and computer technology; (6A) Petitioner had a work-life expectancy of only 11 years; (6B) Petitioner had cooperated in treatment and attempted to return to work on two occasions, but was unable to sustain the work activities; and (6C) Petitioner had permanent restrictions not susceptible to recovery through medical rehabilitation. The Arbitrator finds Entenberg's unrebutted evaluation persuasive.

Based on the above, the Arbitrator finds that Petitioner is permanently and totally disabled.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC017538
Case Name	STACHOWICZ, DOMINIK v. WILSON HILL LLC/GUARD INSURANCE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0420
Number of Pages of Decision	16
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Peter Schlax
Respondent Attorney	Jennifer Kiesewetter

DATE FILED: 8/19/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0420

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dominik Stachowicz,

Petitioner,

vs. NO: 17 WC 17538

Wilson Hill LLC / Guard Insurance,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering causal connection, prospective medical treatment, temporary total disability ("TTD") benefits, and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission reverses the Arbitrator's conclusion that Petitioner's current condition of ill-being is causally related to the work accident. The Commission also vacates the Arbitrator's award of permanent partial disability. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Initially, the Commission notes that prior to the arbitration hearing, the parties consolidated this case with a subsequent case. Case number 17 WC 17972 involves a later work injury that occurred on May 31, 2017. While the parties addressed both cases during the arbitration hearing, the Arbitrator issued separate Decisions for each case. The Commission addresses the issues Petitioner raised on review relating to the companion case in a separate Decision.

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. Petitioner works as a construction laborer and painter for Respondent. His job duties include performing general construction work, painting, and performing other tasks relating to home renovations. On October 18, 2016, he sustained an injury to his lumbar spine while moving equipment. Petitioner testified that while connecting ventilation, he crawled under a table. As he crawled out from under the table, a piece of metal jabbed into his spine. He testified that the wound began to bleed, and he felt low back pain. Petitioner testified that the bleeding stopped later that day; however, he continued to experience lumbar pain. Petitioner continued to work without

any formal restrictions following this work accident; however, his boss did allow him to work light duty for a short period. Petitioner only visited the doctor once in December 2016 and required no further medical treatment relating to this work accident. Petitioner testified that he continued to suffer from lumbar pain following this earlier injury. He continued to work full duty following his December 2016 office visit. On May 31, 2017, Petitioner sustained a second injury to his lumbar spine while loading equipment into his car. Petitioner was eventually diagnosed with lumbar radiculopathy and lumbar spondylosis. His doctor continues to restrict him from returning to work and has recommended Petitioner undergo a lumbar fusion surgery. Petitioner continues to receive medical treatment relating to this subsequent injury. Dr. Erickson, Petitioner's treating doctor, opined that the May 2017 work accident was the most severe injury and was the "…final contributing factor leading to [his] recommendation for consideration of fusion surgery…" (PX 7).

After considering the totality of the evidence, the Commission reverses the Arbitrator's conclusion that Petitioner met his burden of proving his current condition of ill-being is causally related to the October 18, 2016, work accident. The credible evidence shows that Petitioner at the very least sustained an intervening injury on May 31, 2017, that caused significant injury to his lumbar spine. There is no dispute that as a result of the October 18, 2016, work accident, Petitioner was able to continue to work in his normal job for several months without any restrictions. While he testified that he experienced some lumbar pain due to this accident, his pain was not severe, and he was able to delay seeking medical treatment for over two months. This initial work injury also only required one office visit that resulted in the doctor making no recommendations for additional treatment. Contrarily, the May 31, 2017, work accident caused Petitioner to sustain severe lumbar pain. Petitioner sought medical treatment relating to the subsequent accident within two days and has continued to receive ongoing treatment since then. In fact, Petitioner's complaints following the May 2017 work accident were so significant, that his doctor restricted him from returning to work. Currently, Petitioner's doctor has recommended Petitioner undergo a lumbar fusion surgery to improve his condition. The Commission finds the May 31, 2017, work accident is an intervening injury that "…completely breaks the chain between the original work-related injury and the ensuing condition of ill-being." *Par Electric v. Ill. Workers' Comp. Comm'n*, 2018 IL App (3d) 170656WC at ¶56 (citation omitted). Thus, the Commission finds Petitioner's current condition of ill-being is not causally related to the October 18, 2016, work accident.

The Commission also vacates the Arbitrator's conclusion that Petitioner sustained a 2% loss of use of the whole person due to this work accident. This matter proceeded to hearing pursuant to Section 19(b) of the Act. The parties made it clear that the only disputed issues were accident, the date of accident, notice, causal connection, medical treatment and expenses, TTD, and prospective medical treatment. The nature and extent of Petitioner's injury was *not* at issue. Illinois courts have held that it is improper for the Commission to address permanency where the record establishes that permanency was not raised as a pending issue. *See, e.g., Nat'l Freight Indus. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120043 WC. Thus, the Commission must vacate the Arbitrator's award of permanent partial disability.

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 November 22, 2019, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being **is not** causally related to the October 18, 2016, work accident. The May 31, 2017, work accident constitutes an intervening injury that severed any causal connection between Petitioner's current condition and the October 18, 2016, accident.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges, of $93.00 as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that the Commission hereby **vacates** the permanent partial disability awarded by the Arbitrator.

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

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

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

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.

August 19, 2021

o: 6/22/21
TJT/jds
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
NOTICE OF ARBITRATOR DECISION

21IWCC0420

STACHOWICZ, DOMINIK
Employee/Petitioner

Case# **17WC017538**
17WC017972

WILSON HILL LLC/GUARD INSURANCE
Employer/Respondent

On 11/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dominik Stachowicz
Employee/Petitioner

v.

William Hill, LLC/Guard Insurance
Employer/Respondent

Case # **17** WC **17538**

Consolidated cases: **17WC17972**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Rockford**, on **07/10/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/18/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**45,760.00**; the average weekly wage was $**880.00**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

ORDER

- Respondent shall pay reasonable and necessary medical services of $93.00, as provided in Section 8(a) of the Act.
- The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2% loss of use of the man as a whole pursuant to §8(d)(2) of the Act. See attached addendum for the Arbitrator's analysis pursuant to 8.1b 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.

Susan C. Kluzek

Signature of Arbitrator

11/22/19
Date

NOV 22 2019

ICArbDec p. 2

ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIK STACHOWICZ,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 17 WC 17538
	)	(consolidated with 17 WC 17972)
WILLIAM HILL, LLC,/GUARD INS.,	)	
	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

PROCEDURAL HISTORY

Petitioner filed two Applications for Adjustment of Claim against Wilson Home LLC., ("Respondent"). The cases were consolidated prior to the time of hearing.

Respondent Wilson Home LLC., is insured by Acuity for case number 17 WC 17972 and by Guard Insurance Co. for case number 17 WC 17538. The Respondent was represented by separate legal counsel for each filed case.

The application filed for case number 17 WC 17538 was amended to list Guard Insurance as a Respondent under Section 4c of the Act.

On July 10, 2019 both matters proceeded to hearing under Section 19(b) of the Act. Separate decisions and addendums will be issued by the Arbitrator for each case.

FINDINGS OF FACT

17 WC 17538

On October 18, 2016 Petitioner was employed as a construction laborer/painter by Respondent, a residential home remodeling business, and had been so employed for over 5 years (Trans. pp. 9-11). On that date Petitioner was connecting dust collection equipment in Respondent's shop. As Petitioner crawled out from below a table, he struck his back on a large, stationery piece of metal machinery. He experienced immediate back pain and his back began to bleed. (Id., pp. 15-16). Petitioner testified that Dennis Wilson, the owner of Respondent's business, and Dennis Long, Respondent's shop manager, were present at work that day and walked into the shop moments after his accident at which time Petitioner pointed out that he was bleeding from his spine. (Id., pp. 16-17).

Petitioner did not seek immediate medical treatment. In the days that followed the accident his back pain persisted. He informed Wilson of his persistent back pain, inquiring about medical treatment via workers' compensation. (Id.,

pp. 18-20). Petitioner testified that Wilson asked him to wait until the end of the calendar year so that his "rate" wouldn't increase for that year. (Id., pp. 20-21).
In evidence are text messages between Petitioner and Wilson dated December 30, 2016 and January 2, 2017 whereby Petitioner informed Wilson of the following:

> "My back pain is not going away but getting worse and its effecting my performance and ability to work through 8 hours. I have to get this check out asap. Can you notify workmens comp about it. And do I go to their doctor or mine. I cant eat pain killers everyday to be able to walk. Let me know when you find out things. Thanks." (Trans. pp. 22-23, Px12).

On December 30, 2016, Petitioner presented to Presence Medical Group where Dr. Urszula Jablonska noted a history of lower back pain for approximately two months after striking his back on a metal piece at work. (Id., pp. 23-24, Pet. Ex. 1). On exam, a healed, four (4) cm scar on the right side of Petitioner's left spine was noted. Lower back x-rays obtained the same day noted no acute abnormalities although the L5-S1 disk appeared "somewhat diminutive and narrow." (Px1).

Petitioner obtained no additional medical care thereafter and missed no time from work. Dennis Wilson testified that pursuant to the December 31st conversations he had with Petitioner, he offered to pay for a back brace and allowed Petitioner to perform seated work. (Trans. p. 25, 74, 78). Petitioner continued working full time for Respondent until his subsequent work-related injury of May 31, 2017 (consolidated claim 17 WC 17972). Petitioner testified that his back discomfort persisted to a degree up until May 31, 2017.

17 WC 17972
(Consolidated case)

Petitioner testified that he re-injured his back on May 31, 2017 while lifting a 40-pound electric miter saw while at a job site in Kenilworth. (Px1, pp. 26-28). Afterwards he experienced sharp, needle like, stabbing pain in his low back that has persisted ever since. (Id., 28).

Petitioner reported the incident to both Dennis Wilson, who was out of town, and David Long, who was in charge in Wilson's absence, via text messages on May 31, 2017. (Px1, pp. 28-30, Px13). The text message sent by Petitioner to Mr. Long states the following:

> "Im done there. I sent a message to Dennis but seems like he's ignoring me. I lifted the saw back to van and fucked my back again. Im not coming back today. Just letting you know and if you talk to him remind him that I'm waiting for a list of doctors that I can go to that workmens comp will cover." (Px13).

On June 2, 2017 Petitioner presented to Condell Medical Center Emergency Room with a history of sharp, stabbing lower back pain radiating to his bilateral legs that began two days prior after lifting a heavy saw. (Px3, p. 35). Petitioner also reported the history of a work-related back injury that occurred six months prior after a large piece of metal from a machine struck his back causing bruising. (Id.). Lumbar spine x-rays revealed mild degenerative disk disease at L5-S1. At the sacrococcygeal junction it was noted, "the angulation may be related to an old injury or be developmental in nature". (Id., p. 37). A repetitive lower back strain was diagnosed and light duty work restrictions were issued along with prescriptions for Norco, Flexeril and Medrol Dosepack. Petitioner was also advised to follow-up with Dr. Erickson in 3-5 days. (Id., p. 33).

On June 13, 2017 Petitioner presented to Dr. Robert Erickson at The American Center for Spine & Neurosurgery who noted a history of the acute onset of back and neck pain following a lifting incident at work on May 31, 2017.

(Px6, p. 15). Petitioner also reported injury to his low back six to eight months prior when he arose from a bent position, striking his back with force against a shelf. (Id., p. 15). Petitioner recalled bruising and a laceration to his back following the incident and that his back pain had been a "daily problem" since. (Id.). On exam, straight leg raising was positive with referral to the gluteal and posterior thigh on the left side. Lasegue's maneuver was also positive. (Id.). Dr. Erickson noted Petitioner had lumbar radiculopathy that began with the work-related incidents. The doctor prescribed therapy, an MRI, and issued off-work restrictions. (Id., p. 15-16).
On June 27, 2017 MRI revealed disc degeneration at L5-S1 with right foraminal protrusion and impingement on the right L5 nerve root. (Pet. Ex. 6, p. 23). On July 27, 2017 Petitioner presented to Dr. Erickson, who pursuant to exam and review of the recent MRI, recommended that Petitioner undergo a hemilaminectomy at L5-S1 on the right side to address diminished dorsiflexion strength on the right, worsening since his previous visit. (Id., p. 24). Dr. Erickson has continued Petitioner's off work status since that time. (Px6, p. 26; Px7, p. 8, 15 and Px14, p. 10).

On December 26, 2017 Petitioner was examined by Dr. Erickson who noted continued neurologic compromise with positive straight leg raising and gastric weakness on the right side. Dr. Erickson persisted in his recommendation for surgery and recommended an updated MRI. (Px7, pp. 26-27). The MRI, completed on January 17, 2018, showed persistent, moderate, bi-foraminal compromise greater on the right. (Id., p. 4). Dr. Erickson reviewed the MRI, noting further collapse of the L5-S1 segment as compared to the prior MRI. Dr. Erickson amended his surgical recommendation from hemilaminectomy to a fusion procedure. (Px7, p. 6; Trans. p. 36). Petitioner was seen again on January 8, 2019, and found to be unimproved by Dr. Erickson who noted, "Petitioner is likely to receive significant benefit" from surgery. (Px7, p. 13; Trans. p. 36).

Petitioner testified that no offer of light duty was ever communicated to him by Respondent. (Trans. p. 63). Respondent testified he received Petitioner's attorney's written demand for workers' compensation benefits and Petitioner's light duty slip on or about June 15, 2017. (Trans. p. 78, Pet. Ex. 15). Respondent admits that Petitioner's claim for benefits was denied at least as of July 20, 2017. (Trans. p. 67, Pet. Ex. 16).

Petitioner testified that none of his bills have been paid. He further testified that since May 31, 2017, he has worked a couple of side jobs, mostly painting at a home at which is mother is employer as a maid earning approximately $5,000.00. (Trans. pp. 37-39, 60).

Petitioner acknowledged he was involved in an automobile accident in April 2016 for which he underwent a two month course of chiropractic spine care. He testified that he missed no time from work, was able to fulfill all of his work duties, and experienced a complete resolution of his symptoms prior to his first accident. (Trans. pp 12-14).

Regarding Petitioner's April 2016 automobile accident, medical records from Pain Care Consultants reveal that Petitioner presented to David Cavazos, D.C., on April 14, 2016 with pain in his neck, mid and low back and headaches after being rear-ended in a car collision on April 11, 2016. Petitioner began a course of physical therapy and was treated with various medications. (Rx2). During this time period, Petitioner made complaints of neck, mid back, and low back pain. Petitioner also complained of tension headaches and radiation of pain into his gluteals. (Id.) On June 4, 2016, Petitioner's continued complaints of neck, mid back and low back pain were noted by Dr. Cavazos. Petitioner rated his low back pain at a 2/10 and reported his pain occurred 25% of the time. Petitioner reportedly had pain when he stood for more than an hour. On exam, a positive standing leg raise with radiation into the gluteals was noted. A final diagnosis of a cervical, thoracic and lumbar sprain with and tension headaches due to the motor vehicle accident was noted. Dr. Cavazos released Petitioner from treatment at MMI. Dr. Cavazos went on to state the injury from the motor vehicle accident was "permanent and life long" and Petitioner was advised to return to the office in case of any acute exacerbation. (Id.)

Petitioner testified that after being released by Dr. Cavazos he continued to work full duty and experienced no further spinal issues. (Trans. pg. 14.).

Dr. Erickson testified that both of Petitioner's work accidents could have caused some weakening to Petitioner's spine. He testified, however, that it was only after the second accident and Petitioner's inability to continue working that he recommended surgical treatment. (Px14, p. 16-18; Px12).

Petitioner was also examined at Respondent's request by Dr. Frank Phillips on September 12, 2017. (Rx3). Dr. Phillips reviewed Petitioner's medical history and performed an examination. Regarding Petitioner's MRI scan of June 27, 2017, Dr. Phillips testified Petitioner had disc degeneration at L5 with marked disc space narrowing and disc bulging centrally and more prominent towards the right side. (Id., p. 8). Regarding causal connection, Dr. Phillips stated that Petitioner suffered a "short lived exacerbation" of his underlying degenerative condition which predated his May 17, 2017 work accident. (Id., p. 13). Dr. Phillips stated that any surgery which was required would not address pathology that resulted from Petitioner's May 17, 2017 work accident but rather only his underlying degenerative condition. (Id., p. 14). Dr. Phillips acknowledged that Petitioner did not exhibit any Waddell signs on examination. (Id., p. 17). He indicated Petitioner's discs looked "pristine" except for the L5-S1 level. (Id.). He acknowledged that Petitioner was a candidate for surgery based upon the pathology revealed by the MRI and depending on his level of symptoms (Id., p. 18). He acknowledges that Petitioner's MRI revealed at least moderate encroachment over the nerve root at L5-S1. (Id., p. 18). He testified Petitioner provided consistent histories to all of his various medical providers. (Id., p. 19).

Dr. Phillips acknowledged that people with underlying degenerative disc disease may alternately remain symptom free throughout their lives and experience temporary or permanent exacerbations. (Id., p. 20). Dr. Phillips imposed a 20-pound lifting restriction and further advised Petitioner against repetitive lifting. (Id., p. 22).

Testimony of Dennis Wilson

Dennis Wilson testified he is the owner of Wilson Hill, LLC., a renovation and custom cabinetry business. (Id., pg. 64-65). Between October 18, 2016 and December 30, 2016, Petitioner worked for Wilson in a full duty capacity, at times lifting up to 100 pounds. (Id., pg. 71). Petitioner's job duties included painting, carpentry, and working in the cabinet shop. (Id., 70). Wilson acknowledged receipt of Petitioner's text messages regarding his injuries and his need for medical care after both of his injuries. (Id., pp. 74-75). He further testified that the first time Petitioner asked about medical care stemming from his October 18, 2016 accident was on or around December 30, 2016. (Id., pp. 70-1).

Wilson testified that after Petitioner went to the doctor on December 30, 2016, Petitioner returned to work and Wilson allowed Petitioner to perform seated work. Wilson also offered to pay for a back brace which Petitioner declined. (Id., 74). Petitioner continued to work for Wilson until May 31, 2017. At times during this period, Petitioner worked full duty. (Id.). Between December 30, 106 and May 31, 2017, Petitioner never asked Wilson for additional medical treatment. (Id.).

Wilson acknowledged receiving a text message from Petitioner after the May 31, 2017 accident. At that time Wilson was not in Illinois. (Id., pg. 75). Wilson was unaware on June 2, 2017 that Petitioner had sought medical treatment and did not receive any work restrictions or medical slips from Petitioner. After May 31, 2017, Petitioner did not contact Wilson and ask to return to work. (Id.). At no time did Wilson terminate Petitioner nor did he instruct his shop manager to terminate Petitioner. (Id.). Wilson testified he had and continues to have light duty work available for Petitioner and if Petitioner would have contacted him after June 2, 2017, Wilson would have offered him work. (Id., pp. 76-77) Wilson testified he did not contact Petitioner after June 14, 2017 because he

knew Petitioner was represented by an attorney. (Id., 78). Wilson communicated to his insurance company that he had light duty work available for Petitioner but did not know if his insurance company communicated such to Petitioner. (Id., 78). He testified he did provide Petitioner light duty work after his October 18, 2016 work accident because he likes Petitioner and regarded Petitioner as a dependable, hardworking, and credible employee. (Trans. pp. 78-79).

CONCLUSIONS OF LAW

ARBITRATOR'S ASSESSMENT OF PETITIONER'S CREDIBILITY

The Arbitrator found the Petitioner presented at the arbitration hearing as credible. His demeanor including his body language, facial expression, tone and inflection of his voice while testifying left the Arbitrator with the impression that Petitioner was telling the truth. Further, Petitioner's testimony regarding the two alleged accidents is corroborated by the consistent histories he reported to his treating doctors. In addition, the IME doctor acknowledged that Petitioner consistently reported his history to his healthcare providers and Dennis Wilson testified Petitioner was a credible, dependable, hard-working employee. Accordingly, the Arbitrator places a great deal of weight on Petitioner's testimony.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "C" (ACCIDENT), "D' (DATE THEREOF) AND "E" (NOTICE), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner credibly testified to injuring himself on October 18, 2016 when he backed into a stationery piece of machinery at Respondent's shop while attempting to attach dust collection equipment. Dennis Wilson does not dispute that he was present on that day and was aware of the accident. Petitioner did not present for medical treatment until December 30, 2016. Petitioner testified that immediately following the incident, he waited for his bleeding to stop and hoped his pain would abate. When his pain persisted in the days that followed, he informed Wilson and inquired of him about seeking medical attention via workers' compensation. (Trans. pp. 18-20). Wilson, according to Petitioner, asked him to wait until the end of the calendar year so that his "rate" did not go up for that year." (Trans. pp. 20-21). Petitioner did wait and when his back pain persisted he texted Wilson, on December 30, 2016, the following:

> *My back pain is not going away but getting worse and its effecting my performance and ability to work through 8 hours. I have to get this check out asap. Can you notify workmens comp about it. And do I go to their doctor or mine. I cant eat pain killers everyday to be able to walk. Let me know when you find out things. Thanks.* (Trans. pp. 22-23, Pet. Ex. 12).

Wilson acknowledges that he received Petitioner's text messages and accommodated Petitioner, for a period of time, with light duty work.

Based on a preponderance of the evidence including Petitioner's credible testimony, the treating medical records and the testimony of Mr. Wilson, the Arbitrator finds Petitioner did suffer a work accident arising out of and in the course of his employment with Respondent on October 18, 2018 in the manner described and that notice of the accident was given to Respondent in a timely manner.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (CAUSAL CONNECTION), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner credibly testified that he had persistent back discomfort following his October 18, 2016 work accident. His testimony is corroborated by a preponderance of the evidence in the record including the treating medical records of Dr. Jablonski and the text messages in evidence. Respondent allowed Petitioner to perform seated work for a period of time before Petitioner was able to resume his full unrestricted work duties prior to his May 31, 2017 work accident. Dr. Erickson stated that the October 18, 2016 injury could not be discounted as causing additional weakness to Petitioner's pre-existing degenerative disc. The Arbitrator therefore finds Petitioner's current condition of ill being is causally connected, in part, to Petitioner's October 18, 2016 work accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "J" (MEDICAL SERVICES), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner's one visit to Dr. Jablonski wherein he described his work accident, his symptoms and his follow up x-ray constitute reasonable and necessary medical treatment. The Arbitrator therefore finds Respondent liable for Dr. Jablonski's bill totaling $93.00 (Pet. Ex. 2).

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "K" (TTD), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner missed no work following his October 18, 2016 work accident until suffering his re-injury on May 31, 2017. The Arbitrator therefore find the Petitioner is not entitled to any TTD benefits as a result of his October 18, 2016 work accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "O" (PROSPECTIVE MEDICAL), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Following this accident Petitioner sought treatment on only one occasion at which time no further treatment was recommended, no restrictions were instituted, and Petitioner returned to work with no time off prior to May 31, 2017. Accordingly, the Arbitrator awards no prospective medical in this case and will instead consider permanency.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (NATURE AND EXTENT OF THE INJURY), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner obtained no additional medical care for this accident after his one visit on December 30, 2016 with Dr. Urszula Jablonska at which time no additional treatment was recommended and he was released to full duty work. He missed no time from work until his second accident. Dennis Wilson testified he offered to pay for a back brace after this incident but Petitioner declined. Although Petitioner was allowed by Wilson to perform seated work for a time, Petitioner returned to full duty work lifting up to 100 pounds in weight, prior to May 31, 2017.

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 gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Petitioner was employed as a construction/laborer/painter at the time of the accident and returned to work in his prior capacity as a result of said injury. Because of his ability to resume his regular duties shortly after his 10/18/16 accident, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Petitioner was 35-years-old at the time of the accident. Because of his relatively young age, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes the Petitioner earned his customary wages after his 10/18/16 accident until his subsequent accident. Accordingly, the Arbitrator gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner had only 1 doctor visit after his 10/18/16 accident. Because of Dr. Erickson's testimony that Petitioner's 10/8/16 could have weakened Petitioner's pre-existing degenerative disc, the Arbitrator gives *some* weight to this factor.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC017972
Case Name	STACHOWICZ, DOMINIK v. WILSON HILL LLC/GUARD INSURANCE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0421
Number of Pages of Decision	17
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Peter Schlax
Respondent Attorney	Jennifer Kiesewetter

DATE FILED: 8/19/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0421

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dominik Stachowicz,

Petitioner,

vs. NO: 17 WC 17972

Wilson Hill LLC / Guard Insurance,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering accident, causal connection, notice, earnings, medical expenses, prospective medical treatment, and temporary total disability ("TTD") benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission modifies the average weekly wage. The Commission also clarifies the credit granted to Respondent due to post-accident wages earned by Petitioner. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Initially, the Commission notes that prior to the arbitration hearing, the parties consolidated this case with an earlier case. Case number 17 WC 17538 involves an earlier work injury that occurred on October 18, 2016. While the parties addressed both cases during the arbitration hearing, the Arbitrator issued separate Decisions for each case. The Commission addresses the issues Petitioner raised on review relating to the companion case in a separate Decision.

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. Petitioner works as a construction laborer and painter for Respondent. His job duties include performing general construction work, painting, and performing other tasks relating to home renovations. On October 18, 2016, he sustained an injury to his lumbar spine while moving equipment. Petitioner continued to work without any restrictions following this work accident. He visited the doctor once in December 2016 and required no further medical treatment relating to this earlier work accident. Petitioner testified that he continued to suffer from lumbar pain following this earlier injury.

On May 31, 2017, Petitioner sustained a second injury to his lumbar spine while loading equipment into his car. Petitioner testified that he transported equipment, including a 40-pound electric miter saw to a job site. He unloaded the saw and used it to cut materials he needed for a home renovation. Petitioner then began to load the equipment back into his car. He testified that when he bent down to lift the 40-pound electric miter saw, he felt significant pain in his low back. Petitioner testified that the pain he felt when he bent to lift the saw was, "…almost like somebody put a needle in [his] spine or more like [he] got stabbed with something almost." (Tr. at 28). Petitioner notified both Dennis Wilson, the owner of the company, and David Long, the shop manager, of his injury that same day. Petitioner visited the ER on June 2, 2017, and complained of worsening lumbar pain that radiated into both legs. Petitioner was diagnosed with a repetitive strain injury of the low back.

Dr. Erickson first examined Petitioner on June 13, 2017, and diagnosed Petitioner with lumbar radiculopathy. A June 27, 2017, lumbar MRI revealed L5-S1 disc degeneration with right foraminal protrusion impinging upon the exiting right L5 nerve root with resulting moderate foraminal narrowing. In late July 2017, Petitioner complained of increasing right leg numbness and worsening right leg pain. Dr. Erickson believed Petitioner was a good candidate for a hemilaminectomy at L5/S1 on the right. Petitioner returned to Dr. Erickson in December 2017 with complaints of pain radiating down to the first and second toes of the right foot. The doctor diagnosed Petitioner with lumbar spondylosis and continued to recommend a right hemilaminectomy at L5-S1. A January 17, 2018, lumbar MRI revealed the following: 1) shallow disc osteophyte complex and facet arthropathy at L5-S1 with slight improvement in right foraminal disc extrusion; 2) moderate biforaminal stenosis, right greater than left still present; and, 3) early facet arthropathy throughout the remainder of the lumbosacral spine with no significant disc protrusion, central or neural foraminal stenosis. On February 13, 2018, Dr. Erickson recommended Petitioner undergo a lumbar fusion at L5/S1. He last examined Petitioner on January 8, 2019. Petitioner continued to complain of moderate to severe chronic low back pain. He told the doctor that he wants to proceed with the recommended fusion surgery.

In April 2016, Petitioner injured his back and neck in a motor vehicle accident. This accident was not work-related. Petitioner complained of cervical, thoracic, and lumbar pain, as well as headaches following the accident. He received treatment from a chiropractor and reached maximum medical improvement ("MMI") on June 4, 2016. Dr. Erickson testified that Petitioner's ongoing complaints and need for the recommended lumbar fusion surgery are causally related to the May 2017 work accident. Dr. Phillips examined Petitioner on behalf of Respondent pursuant to Section 12 of the Act on September 12, 2017. He opined that the May 2017 work accident caused a temporary aggravation of Petitioner's preexisting low back symptoms. Dr. Phillips opined that Petitioner's current complaints are not related to the May 2017 work accident; instead, he believed Petitioner's symptoms are related to his underlying degenerative condition. He further opined that Petitioner reached MMI within six weeks after the work accident and required no further medical treatment.

Petitioner testified that he has remained off work pursuant to the work restrictions provided by Dr. Erickson. He testified that he has performed a few side jobs since the work accident. Petitioner testified that these jobs consisted of tasks such as painting (interior and exterior), washing home exteriors, and hanging pictures. Petitioner estimated he earned approximately

$5,000 while performing these side jobs. Petitioner testified that he wants to proceed with the recommended lumbar fusion surgery.

After considering the totality of the evidence, the Commission modifies Petitioner's average weekly wage ("AWW"). The Arbitrator concluded Respondent stipulated that Petitioner earned $45,760.00 in the 52 weeks before the work accident and has a corresponding AWW of $880.00. After reviewing the record, the Commission finds Respondent disputed Petitioner's earnings and alleged Petitioner has an AWW of $774.87 for the May 31, 2017, work accident. Respondent indicated that Petitioner's earnings were in dispute on the Request for Hearing form and confirmed the dispute on the record. Both parties submitted identical wage statements in this matter. (PX 11; RX 4). Petitioner testified that any overtime he worked was purely voluntary. After carefully reviewing the wage statement, the Commission finds Petitioner earned $40,293.00 in the 52 weeks prior to this work accident. The Commission further finds that Petitioner has an AWW of $774.87.

Finally, the Commission affirms the Arbitrator's conclusion that Respondent is entitled to a credit in the amount of $5,000.00 due to wages Petitioner earned after the work accident. Petitioner testified that although he was restricted from working in his normal job with Respondent, he earned $5,000.00 by completing a few odd jobs. These jobs included tasks such as painting, washing of exteriors, and hanging pictures. Petitioner did not regularly work following the work accident and did not earn regular or continuous income after the work accident. The Commission finds that Petitioner's post-accident earnings constitute occasional wages. Illinois courts have consistently determined that the earning of occasional wages by a claimant does not preclude a finding that Petitioner is temporarily totally disabled. *See, e.g., Mech. Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, 761 (2003). Thus, the Commission affirms the Arbitrator's conclusion that Petitioner met his burden of proving he is entitled to TTD benefits from June 2, 2017, through July 10, 2019. Respondent is entitled to a credit in the amount of $5,000.00 for the occasional wages Petitioner earned after the date of accident.

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 November 22, 2019, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being is causally related to the May 31, 2017, work accident.

IT IS FURTHER ORDERED that Petitioner earned $40,293.00 in the 52 weeks prior to the work accident and has an AWW of $774.87.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of $**516.58**/week for **109-6/7** weeks, commencing **June 2, 2017** through **July**

10, 2019, as provided in Section 8(b) of the Act. Respondent shall receive a credit in the amount of $5,000 for the occasional wages Petitioner earned after the work accident.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges in the amount of $5,398.00 as itemized in PX 5, 8, 9, and 10, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall approve and pay for reasonable and necessary prospective medical treatment in the form of the lumbar fusion surgery at L5/S1 as recommended by Dr. Erickson.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $57,000.00. 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.

August 19, 2021

o: 6/22/21
TJT/jds
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
NOTICE OF ARBITRATOR DECISION

21IWCC0421

STACHOWICZ, DOMINIK
Employee/Petitioner

Case# **17WC017972**

17WC017538

WILSON HILL LLC/GUARD INSURANCE
Employer/Respondent

On 11/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

5074 QUINTAIROS PRIETO WOOD & BOYER
JENNIFER KIESEWETTER
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dominik Stachowicz
Employee/Petitioner

v.

William Hill, LLC/Guard Insurance
Employer/Respondent

Case # **17** WC **17972**

Consolidated cases: **17 WC 17538**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Rockford**, on **07/10/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/31/17**, 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 $**45,760.00**; the average weekly wage was $**880.00**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

ORDER

- **Respondent shall pay reasonable and necessary medical services of , as provided in Section 8(a) of the Act totaling $5,398.00 as itemized in Petitioner's Exhibits 5, 8, 9 and 10.**
- **The Arbitrator finds the prospective medical treatment prescribed by Dr. Erickson is reasonable and necessary and orders Respondent to approve, authorize and pay, per the fee schedule, all diagnostic pre-surgery testing as well as the fusion surgery recommended by Dr. Erickson.**
- **Petitioner is entitled to TTD benefits for the period from June 2, 2017 through the date of hearing on July 10, 2019.**
- **Respondent is entitled to a TTD credit in the amount of $5,000.00.**

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.

Susan A. Mynatt

Signature of Arbitrator

11/22/19

Date

NOV 22 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIK STACHOWICZ,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 17 WC 17972
	)	(consolidated with 17 WC 17538)
WILLIAM HILL, LLC,/GUARD INS.,	)	
	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

PROCEDURAL HISTORY

Petitioner filed two Applications for Adjustment of Claim against Wilson Home LLC., ("Respondent"). The cases were consolidated prior to the time of hearing.

Respondent Wilson Home LLC., is insured by Acuity for case number 17 WC 17972 and by Guard Insurance Co. for case number 17 WC 17538. The Respondent was represented by separate legal counsel for each filed case.

The application filed for case number 17 WC 17538 was amended to list Guard Insurance as a Respondent under Section 4c of the Act.

On July 10, 2019 both matters proceeded to hearing under Section 19(b) of the Act. Separate decisions and addendums will be issued by the Arbitrator for each case.

FINDINGS OF FACT

17 WC 17538
(Consolidated case)

On October 18, 2016 Petitioner was employed as a construction laborer/painter by Respondent, a residential home remodeling business, and had been so employed for over 5 years (Trans. pp. 9-11). On that date Petitioner was connecting dust collection equipment in Respondent's shop. As Petitioner crawled out from below a table, he struck his back on a large, stationery piece of metal machinery. He experienced immediate back pain and his back began to bleed. (Id., pp. 15-16). Petitioner testified that Dennis Wilson, the owner of Respondent's business, and Dennis Long, Respondent's shop manager, were present at work that day and walked into the shop moments after his accident at which time Petitioner pointed out that he was bleeding from his spine. (Id., pp. 16-17).

Petitioner did not seek immediate medical treatment. In the days that followed the accident his back pain persisted. He informed Wilson of his persistent back pain, inquiring about medical treatment via workers' compensation. (Id.,

pp. 18-20). Petitioner testified that Wilson asked him to wait until the end of the calendar year so that his "rate" wouldn't increase for that year. (Id., pp. 20-21).
In evidence are text messages between Petitioner and Wilson dated December 30, 2016 and January 2, 2017 whereby Petitioner informed Wilson of the following:

> "My back pain is not going away but getting worse and its effecting my performance and ability to work through 8 hours. I have to get this check out asap. Can you notify workmens comp about it. And do I go to their doctor or mine. I cant eat pain killers everyday to be able to walk. Let me know when you find out things. Thanks." (Trans. pp. 22-23, Px12).

On December 30, 2016, Petitioner presented to Presence Medical Group where Dr. Urszula Jablonska noted a history of lower back pain for approximately two months after striking his back on a metal piece at work. (Id., pp. 23-24, Pet. Ex. 1). On exam, a healed, four (4) cm scar on the right side of Petitioner's left spine was noted. Lower back x-rays obtained the same day noted no acute abnormalities although the L5-S1 disk appeared "somewhat diminutive and narrow." (Px1).

Petitioner obtained no additional medical care thereafter and missed no time from work. Dennis Wilson testified that pursuant to the December 31st conversations he had with Petitioner, he offered to pay for a back brace and allowed Petitioner to perform seated work. (Trans. p. 25, 74, 78). Petitioner continued working full time for Respondent until his subsequent work-related injury of May 31, 2017 (consolidated claim 17 WC 17972). Petitioner testified that his back discomfort persisted to a degree up until May 31, 2017.

17 WC 17972

Petitioner testified that he re-injured his back on May 31, 2017 while lifting a 40-pound electric miter saw while at a job site in Kenilworth. (Px1, pp. 26-28). Afterwards he experienced sharp, needle like, stabbing pain in his low back that has persisted ever since. (Id., 28).

Petitioner reported the incident to both Dennis Wilson, who was out of town, and David Long, who was in charge in Wilson's absence, via text messages on May 31, 2017. (Px1, pp. 28-30, Px13). The text message sent by Petitioner to Mr. Long states the following:

> "Im done there. I sent a message to Dennis but seems like he's ignoring me. I lifted the saw back to van and fucked my back again. Im not coming back today. Just letting you know and if you talk to him remind him that I'm waiting for a list of doctors that I can go to that workmens comp will cover." (Px13).

On June 2, 2017 Petitioner presented to Condell Medical Center Emergency Room with a history of sharp, stabbing lower back pain radiating to his bilateral legs that began two days prior after lifting a heavy saw. (Px3, p. 35). Petitioner also reported the history of a work-related back injury that occurred six months prior after a large piece of metal from a machine struck his back causing bruising. (Id.). Lumbar spine x-rays revealed mild degenerative disk disease at L5-S1. At the sacrococcygeal junction it was noted, "the angulation may be related to an old injury or be developmental in nature". (Id., p. 37). A repetitive lower back strain was diagnosed and light duty work restrictions were issued along with prescriptions for Norco, Flexeril and Medrol Dosepack. Petitioner was also advised to follow-up with Dr. Erickson in 3-5 days. (Id., p. 33).

On June 13, 2017 Petitioner presented to Dr. Robert Erickson at The American Center for Spine & Neurosurgery who noted a history of the acute onset of back and neck pain following a lifting incident at work on May 31, 2017. (Px6, p. 15). Petitioner also reported injury to his low back six to eight months prior when he arose from a bent

position, striking his back with force against a shelf. (Id., p. 15). Petitioner recalled bruising and a laceration to his back following the incident and that his back pain had been a "daily problem" since. (Id.). On exam, straight leg raising was positive with referral to the gluteal and posterior thigh on the left side. Lasegue's maneuver was also positive. (Id.). Dr. Erickson noted Petitioner had lumbar radiculopathy that began with the work-related incidents. The doctor prescribed therapy, an MRI, and issued off-work restrictions. (Id., p. 15-16).

On June 27, 2017 MRI revealed disc degeneration at L5-S1 with right foraminal protrusion and impingement on the right L5 nerve root. (Pet. Ex. 6, p. 23). On July 27, 2017 Petitioner presented to Dr. Erickson, who pursuant to exam and review of the recent MRI, recommended that Petitioner undergo a hemilaminectomy at L5-S1 on the right side to address diminished dorsiflexion strength on the right, worsening since his previous visit. (Id., p. 24). Dr. Erickson has continued Petitioner's off work status since that time. (Px6, p. 26; Px7, p. 8, 15 and Px14, p. 10).

On December 26, 2017 Petitioner was examined by Dr. Erickson who noted continued neurologic compromise with positive straight leg raising and gastric weakness on the right side. Dr. Erickson persisted in his recommendation for surgery and recommended an updated MRI. (Px7, pp. 26-27). The MRI, completed on January 17, 2018, showed persistent, moderate, bi-foraminal compromise greater on the right. (Id., p. 4). Dr. Erickson reviewed the MRI, noting further collapse of the L5-S1 segment as compared to the prior MRI. Dr. Erickson amended his surgical recommendation from hemilaminectomy to a fusion procedure. (Px7, p. 6; Trans. p. 36). Petitioner was seen again on January 8, 2019, and found to be unimproved by Dr. Erickson who noted, "Petitioner is likely to receive significant benefit" from surgery. (Px7, p. 13; Trans. p. 36).

Petitioner testified that no offer of light duty was ever communicated to him by Respondent. (Trans. p. 63). Respondent testified he received Petitioner's attorney's written demand for workers' compensation benefits and Petitioner's light duty slip on or about June 15, 2017. (Trans. p. 78, Pet. Ex. 15). Respondent admits that Petitioner's claim for benefits was denied at least as of July 20, 2017. (Trans. p. 67, Pet. Ex. 16).

Petitioner testified that none of his bills have been paid. He further testified that since May 31, 2017, he has worked a couple of side jobs, mostly painting at a home at which is mother is employer as a maid earning approximately $5,000.00. (Trans. pp. 37-39, 60).

Petitioner acknowledged he was involved in an automobile accident in April 2016 for which he underwent a two month course of chiropractic spine care. He testified that he missed no time from work, was able to fulfill all of his work duties, and experienced a complete resolution of his symptoms prior to his first accident. (Trans. pp 12-14).

Regarding Petitioner's April 2016 automobile accident, medical records from Pain Care Consultants reveal that Petitioner presented to David Cavazos, D.C., on April 14, 2016 with pain in his neck, mid and low back and headaches after being rear-ended in a car collision on April 11, 2016. Petitioner began a course of physical therapy and was treated with various medications. (Rx2). During this time period, Petitioner made complaints of neck, mid back, and low back pain. Petitioner also complained of tension headaches and radiation of pain into his gluteals. (Id.) On June 4, 2016, Petitioner's continued complaints of neck, mid back and low back pain were noted by Dr. Cavazos. Petitioner rated his low back pain at a 2/10 and reported his pain occurred 25% of the time. Petitioner reportedly had pain when he stood for more than an hour. On exam, a positive standing leg raise with radiation into the gluteals was noted. A final diagnosis of a cervical, thoracic and lumbar sprain with and tension headaches due to the motor vehicle accident was noted. Dr. Cavazos released Petitioner from treatment at MMI. Dr. Cavazos went on to state the injury from the motor vehicle accident was "permanent and life long" and Petitioner was advised to return to the office in case of any acute exacerbation. (Id.)

Petitioner testified that after being released by Dr. Cavazos he continued to work full duty and experienced no further spinal issues. (Trans. pg. 14.).

Dr. Erickson testified that both of Petitioner's work accidents could have caused some weakening to Petitioner's spine. He testified, however, that it was only after the second accident and Petitioner's inability to continue working that he recommended surgical treatment. (Px14, p. 16-18; Px12).
Petitioner was also examined at Respondent's request by Dr. Frank Phillips on September 12, 2017. (Rx3). Dr. Phillips reviewed Petitioner's medical history and performed an examination. Regarding Petitioner's MRI scan of June 27, 2017, Dr. Phillips testified Petitioner had disc degeneration at L5 with marked disc space narrowing and disc bulging centrally and more prominent towards the right side. (Id., p. 8). Regarding causal connection, Dr. Phillips stated that Petitioner suffered a "short lived exacerbation" of his underlying degenerative condition which predated his May 17, 2017 work accident. (Id., p. 13). Dr. Phillips stated that any surgery which was required would not address pathology that resulted from Petitioner's May 17, 2017 work accident but rather only his underlying degenerative condition. (Id., p. 14). Dr. Phillips acknowledged that Petitioner did not exhibit any Waddell signs on examination. (Id., p. 17). He indicated Petitioner's discs looked "pristine" except for the L5-S1 level. (Id.). He acknowledged that Petitioner was a candidate for surgery based upon the pathology revealed by the MRI and depending on his level of symptoms (Id., p. 18). He acknowledges that Petitioner's MRI revealed at least moderate encroachment over the nerve root at L5-S1. (Id., p. 18). He testified Petitioner provided consistent histories to all of his various medical providers. (Id., p. 19).

Dr. Phillips acknowledged that people with underlying degenerative disc disease may alternately remain symptom free throughout their lives and experience temporary or permanent exacerbations. (Id., p. 20). Dr. Phillips imposed a 20-pound lifting restriction and further advised Petitioner against repetitive lifting. (Id., p. 22).

Testimony of Dennis Wilson

Dennis Wilson testified he is the owner of Wilson Hill, LLC., a renovation and custom cabinetry business. (Id., pg. 64-65). Between October 18, 2016 and December 30, 2016, Petitioner worked for Wilson in a full duty capacity, at times lifting up to 100 pounds. (Id., pg. 71). Petitioner's job duties included painting, carpentry, and working in the cabinet shop. (Id., 70). Wilson acknowledged receipt of Petitioner's text messages regarding his injuries and his need for medical care after both of his injuries. (Id., pp. 74-75). He further testified that the first time Petitioner asked about medical care stemming from his October 18, 2016 accident was on or around December 30, 2016. (Id., pp. 70-1).

Wilson testified that after Petitioner went to the doctor on December 30, 2016, Petitioner returned to work and Wilson allowed Petitioner to perform seated work. Wilson also offered to pay for a back brace which Petitioner declined. (Id., 74). Petitioner continued to work for Wilson until May 31, 2017. At times during this period, Petitioner worked full duty. (Id.). Between December 30, 106 and May 31, 2017, Petitioner never asked Wilson for additional medical treatment. (Id.).

Wilson acknowledged receiving a text message from Petitioner after the May 31, 2017 accident. At that time Wilson was not in Illinois. (Id., pg. 75). Wilson was unaware on June 2, 2017 that Petitioner had sought medical treatment and did not receive any work restrictions or medical slips from Petitioner. After May 31, 2017, Petitioner did not contact Wilson and ask to return to work. (Id.). At no time did Wilson terminate Petitioner nor did he instruct his shop manager to terminate Petitioner. (Id.). Wilson testified he had and continues to have light duty work available for Petitioner and if Petitioner would have contacted him after June 2, 2017, Wilson would have offered him work. (Id., pp. 76-77) Wilson testified he did not contact Petitioner after June 14, 2017 because he knew Petitioner was represented by an attorney. (Id., 78). Wilson communicated to his insurance company that he

had light duty work available for Petitioner but did not know if his insurance company communicated such to Petitioner. (Id., 78). He testified he did provide Petitioner light duty work after his October 18, 2016 work accident because he likes Petitioner and regarded Petitioner as a dependable, hardworking, and credible employee. (Trans. pp. 78-79).

CONCLUSIONS OF LAW

ARBITRATOR'S ASSESSMENT OF PETITIONER'S CREDIBILITY

The Arbitrator found the Petitioner presented at the arbitration hearing as credible. His demeanor including his body language, facial expression, tone and inflection of his voice while testifying left the Arbitrator with the impression that Petitioner was telling the truth. Further, Petitioner's testimony regarding the two alleged accidents is corroborated by the consistent histories he reported to his treating doctors. In addition, the IME doctor acknowledged that Petitioner consistently reported his history to his healthcare providers and Dennis Wilson testified Petitioner was a credible, dependable, hard-working employee. Accordingly, the Arbitrator places a great deal of weight on Petitioner's testimony.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "C" (ACCIDENT), "D' (DATE THEREOF) AND "E" (NOTICE), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Petitioner credibly testified that he felt a sudden severe onset of pain on May 31, 2017 when he lifted 40-pound saw while working for Respondent at a job site in Kenilworth, Illinois. Petitioner testified and Respondent acknowledged receipt of text messages on or about May 31, 2017 describing the injury and the need for medical treatment. Respondent further acknowledged receipt of Petitioner's attorney's June 15, 2017 letter enclosing both his light duty slip and his Application for Adjustment of Claim. After careful consideration of the evidence contained in the record, the Arbitrator finds that Petitioner did suffer an accident on May 31, 2017 arising out of and in the course of his employment with Respondent in the manner described and that he gave Respondent timely notice of same.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (CAUSAL CONNECTION), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Petitioner sought medical care at Condell Medical Center within days of his May 31, 2017 accident. He was diagnosed with a back injury and referred to Dr. Erickson who, pursuant to exam, noted neurologic compromise consistent with subsequent MRI. Petitioner was working full duty prior to the accident on May 31, 2017 but has not been able to work since. Respondent testified that Petitioner had worked for him for over five years and that Petitioner is a hardworking, dependable, reliable and credible employee. Dr. Phillips acknowledged that Petitioner exhibited no Waddell signs and that his symptoms were consistent with his examination. Dr. Erickson noted Petitioner's need for surgery relates to his severe pain, neurologic compromise and inability to work. Dr. Phillips imposed a 20-pound/avoidance of repetitive bending, work restriction on Petitioner.

After careful consideration of the evidence contained in the record, the Arbitrator finds Petitioner's current condition of ill being is causally related to Petitioner's May 31, 2017 work accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "G" (EARNINGS), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Petitioner credibly testified he worked full-time, 40 hours per week for Respondent, earning $22.00 per hour. Respondent stipulated in Case No. 17 WC 17538, consolidated herein, that Petitioner had an average weekly wage of $880.00.

After careful consideration of the evidence contained in the record, the Arbitrator finds Petitioner's average weekly wage was $880.00.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "J" (MEDICAL SERVICES), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator reiterates her findings regarding accident and causal connection. After reviewing the evidence contained in the record, including Petitioner's credible testimony and the treating medical records, the Arbitrator finds that Petitioner's treatment at constituted reasonable and necessary medical care. The Respondent's examining physician, Dr. Phillips, does not challenge the reasonableness or necessity of Petitioner's treatment to date. The Arbitrator therefore finds Respondent liable for medical expense totaling $5,398.00 as itemized in Petitioner's Exhibits 5, 8, 9 and 10.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "K" (PROSPECTIVE MEDICAL CARE), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator reiterates her findings regarding causal connection. The MRI, completed on June 27, 2017 revealed disc degeneration at L5-S1 with right foraminal protrusion and impingement on the right L5 nerve root. (Px6, p. 23). Petitioner returned to Dr. Erickson on July 27, 2017 at which time the doctor noted diminished dorsiflexion strength on the right, worsening since his previous visit. (Id., p. 24). Dr. Erickson has continued Petitioner's off work status since that time. (Px6, p. 26; Px7, p. 8, 15 and Px14, p. 10). On December 26, 2017 Dr. Erickson noted continued neurologic compromise with positive straight leg raising and gastric weakness on the right side. An updated MRI, completed on January 17, 2018, showed persistent, moderate bi-foraminal compromise greater on the right. (Id., p. 4). Dr. Erickson reviewed the MRI, noting further collapse of the L5-S1 segment as compared to the prior MRI and therefore recommended fusion surgery. (Px7, p. 6; Trans. p. 36). Petitioner was seen again on January 8, 2019, was found to be unimproved. Dr. Erickson stated "Petitioner is likely to receive significant benefit" from surgery. (Px7, p. 13; Trans. p. 36).

Dr. Phillips does not challenge the reasonableness or necessity of Dr. Erickson's recommendation for fusion surgery given the Petitioner's MRI findings and his symptoms. Although Dr. Erickson disputes causal connection, the Arbitrator again notes that Dr. Phillips himself imposed a 20 pound lifting/avoidance of repetitive bending restriction on Petitioner. This restriction was not in place prior to Petitioner's May 17, 2017 accident. Petitioner credibly testified to the severity of his ongoing pain. Respondent has admitted that Petitioner is a credible, hardworking employee. Dr. Phillips noted Petitioner's reported symptoms were not in excess of his examination.

After careful consideration of the evidence contained in the record, the Arbitrator finds Petitioner is entitled to prospective medical care in the form of the fusion surgery recommended by Dr. Erickson.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (TTD) and "N" (RESPONDENT CREDIT), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator reiterates the above findings. Petitioner has not worked since being restricted to light duty by physicians at Condell on June 2, 2017. Respondent himself states he has light duty available. It is undisputed that Respondent's workers' compensation carrier has disputed Petitioner's claim for workers' compensation benefits from the outset. Respondent concedes that he is not aware of any communication provided to Petitioner regarding

availability of light duty. Dr. Erickson has reasonably restricted Petitioner from all work since he began treating Petitioner. Petitioner has a significant level of pain consistent with severe abnormalities revealed by both neurologic and MRI examination. Accordingly, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from the period of June 2, 2017 through the date of hearing on July 10, 2019. Petitioner admits to earning up to $5,000.00 doing limited odd jobs since June 2, 2017 in order to purchase food. The Arbitrator therefore finds Respondent is entitled to a "TTD credit" in the amount of $5,000.00.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC002344
Case Name	VAN BUREN, STEVEN v. MEADE ELECTRIC CO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0422
Number of Pages of Decision	12
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Bryan OConnor
Respondent Attorney	Daniel Arkin

DATE FILED: 8/19/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0422

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Van Buren,

Petitioner,

vs. NO: 18 WC 2344

Meade Electric Co.,

Respondent.

DECISION AND OPINION ON REVIEW

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

Finding of Facts

Petitioner worked for Respondent as a crew foreman. In that position, he worked on a crew that performed underground work for ComEd. On February 17, 2015, the date of accident, Petitioner was working to expand CTA tracks. The crew was exposing, breaking, and moving the duct run to allow the installation of new bridge abutments. Petitioner testified that the duct run is underground and supplies electric power to the entire area between manholes. Petitioner testified that the duct run where he worked had 12 cables in the pipe. The cables were live and were running at 12,000 volts.

On the date of accident, Petitioner was wearing his standard personal protection equipment including a special jumpsuit made to withstand blasts or fires, a balaclava, and a helmet. Petitioner described the balaclava as similar to a ski mask. While using a hydraulic hammer in a trench, the hammer went through the pipe. Petitioner testified that the hydraulic hammer hit the live cable and he "…received a 12,000-volt blast in the face." (Tr. at 21). Petitioner testified that he does not remember anything for the first 1.5 minutes following the explosion. When he regained consciousness, his jumpsuit was on fire. Petitioner testified that the force of the explosion knocked him around two to three feet backwards. Petitioner testified that immediately following the blast, his face was black, and his skin felt very tight. He was taken to the ER via ambulance where he

reported sustaining a flash burn to his face after his drill hit a live wire. Although Petitioner's face was completely covered with safety gear, including goggles, he sustained burns due to the flash penetrating underneath his face mask. The examination revealed flash burns to the chin/cheeks, mouth and lips, and the left ear. The doctor diagnosed Petitioner with superficial burns of the face, head, and/or neck. The doctor cleaned and debrided the superficial partial burns and applied an ointment.

Dr. Rodarte examined Petitioner on February 19, 2015, and diagnosed Petitioner with a second-degree facial burn. He prescribed Bacitracin ointment and administered a tetanus shot. That same day, Petitioner also visited Dr. Winters, his primary care physician. Dr. Winters determined that Petitioner sustained first and second-degree burns to his nose, ear, cheeks, and chin. Petitioner was restricted from work as he was unable to wear the required protective facial gear. On February 23, 2015, Dr. Rodarte continued to prescribe work restrictions. On May 6, 2017, Dr. Jazayerli examined Petitioner. Petitioner complained of skin lesions on his face that he reported having for years. Dr. Jazayerli's examination revealed actinic keratoses on the face and left ear. He treated four lesions on the face and left ear with liquid nitrogen. Petitioner returned to Dr. Jazayerli in January 2018. The doctor treated one lesion with liquid nitrogen. Petitioner was to follow up in another year.

Petitioner testified that the face cream prescribed by his doctors helped heal his skin. He testified that his face peeled approximately five to six times in one month. When asked whether he experienced pain during his recovery, Petitioner testified, "…not as much as I thought I would be. The cream basically formed kind of a soothing remedy to everything. But still, it was pretty much, still pretty traumatic." (Tr. at 30). Petitioner returned to work in his original position and continued to work for Respondent in that position for several years following the work incident. Although he has since left his employment with Respondent for reasons unrelated to the work incident, he continues to work underground. After leaving Respondent's employment, he worked at a pipeline company. He recently started a new position with a gas supplier for Nicor Gas. Petitioner testified that he remains a foreman and continues to run an underground crew and installs service and main line to Nicor Gas. Petitioner testified that his work duties have generally remained the same and he continues to work in manholes.

Petitioner testified that this work accident was the most traumatic experience he ever had in over 26 years of performing this type of work. He testified that when he hears a loud noise behind or around him, he is startled. He continues to work near live or energized wires and for several years following the work accident the sudden sound of a noise would startle him. He testified that the sound of a loud noise while he worked would affect him momentarily. He testified that if he currently hears a loud noise reminiscent of the work incident, he momentarily returns to the work incident. Petitioner testified that he has never sought any treatment from a therapist, psychologist, or other mental health professional relating to any emotional distress as a result of the work incident. Petitioner testified that due to the facial trauma he sustained, he continues to "…feel the cold…" differently. (Tr. at 35). He always tries to protect his face, but he continues to feel things differently than he did before the work incident. He testified that his doctors told him that his face has healed well.

Petitioner clarified on the record that he was not seeking any partial permanent disability

compensation due to any disfigurement. Instead, he sought compensation based on a claim of emotional distress.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). After carefully considering the totality of the evidence, the Commission reverses the Arbitrator's conclusion Petitioner sustained a psychological injury as a result of the February 17, 2015, work incident. However, the Commission finds Petitioner met his burden of proving his current condition of ill-being regarding his physical condition is causally related to the work incident. The Commission also modifies the permanent partial disability awarded by the Arbitrator. The Commission affirms and adopts the remainder of the Decision of the Arbitrator.

Respondent does not dispute that Petitioner sustained physical injuries due to the February 17, 2015, work accident. Petitioner sustained first and second-degree burns on various parts of his face as well as his left ear. The medical records show that Petitioner's facial burns healed well. However, Petitioner has suffered from skin lesions on his face and left ear in the years following his injury. Petitioner's injury and treatment is well-documented by the medical records. Based on the credible evidence, including Petitioner's testimony and the medical records, the Commission finds Petitioner's current physical condition of ill-being is causally related to the work incident.

The Arbitrator concluded Petitioner met his burden of proving he sustained a psychological injury due to the February 17, 2015, work incident. After carefully considering the totality of the evidence, the Commission reverses this conclusion. While Illinois courts have long recognized that a physical injury can in certain circumstances cause a mental or psychological injury, the Commission finds Petitioner failed to prove he sustained any psychological injury. There is no question that Petitioner suffered a serious and frightening accident. However, Petitioner admittedly never sought any medical treatment for any mental injury or trauma relating to the work incident. In fact, there is no evidence that Petitioner ever raised the issue of any emotional stress or trauma to any of his medical providers. Furthermore, the Commission does not find that Petitioner's testimony proved he sustained a mental or psychological injury. Petitioner testified that this work incident was the most traumatic experience he ever had while working underground. However, his only possible emotional trauma is that he is only startled for a moment whenever he unexpectedly hears a loud noise or bang behind him. Petitioner testified that his reaction truly lasts for only a moment. Despite this momentary fright when he hears an unexpected loud noise, Petitioner has continued to work underground performing essentially the same duties as he performed before the work accident. The Commission agrees with the Arbitrator's conclusion that Petitioner testified credibly regarding his current condition; however, the Commission finds Petitioner's testimony does not support a finding that Petitioner sustained a psychological injury as a result of the work incident.

Finally, the Commission must modify the Arbitrator's conclusion that Petitioner sustained a 10% loss of use of the whole person due to the work incident. After carefully considering the totality of the evidence and analyzing the five factors pursuant to Section 8.1b(b) of the Act, the Commission finds Petitioner sustained a 2% loss of use of the whole person. Petitioner sustained

first and second-degree burns on several parts of his face and left ear. While the burns healed well, the credible evidence reveals that Petitioner continues to suffer residual symptoms from his injuries. Petitioner credibly testified that as a result of the facial trauma he sustained, he now feels certain sensations differently on his face. Petitioner credibly testified that he feels the cold weather on his facial skin differently and always tries to protect the skin. He has also suffered from facial lesions in the past and continues to follow up with Dr. Jazayerli each year to monitor this condition. Additionally, despite the serious nature of the Petitioner's work accident, Petitioner has continued to work in the same type of job and perform essentially all the same job duties as he performed before the work accident. For the foregoing reasons, the Commission finds Petitioner sustained a 2% loss of use of the whole person as a result of the February 17, 2015, work incident.

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 April 17, 2019, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current physical condition of ill-being is causally related to the February 15, 2015, work incident. Petitioner failed to prove he sustained a psychological injury due to the work incident.

IT IS FURTHER ORDERED Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 10 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.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,454.00. 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.

August 19, 2021

o: 6/22/21
TJT/jds
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
NOTICE OF ARBITRATOR DECISION

VAN BUREN, STEVEN
Employee/Petitioner

Case# **18WC002344**

MEADE ELECTRIC CO
Employer/Respondent

On 4/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1414 O'CONNOR LAW GROUP LLC
BRYAN J O'CONNOR
140 S DEARBORN ST SUITE 320
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
DANIEL ARKIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Van Burren
Employee/Petitioner

v.

Meade Electric Co.
Employer/Respondent

Case # **18** WC **002344**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **February 26, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 17, 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 $**80,961.40**; the average weekly wage was $**1556.95**.

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

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

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

Respondent shall be given a credit 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

Permanent Partial Disability

Based on the factors in 820 ILCS 305/8.1b, and the record taken as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 10% of the person as a whole (50 weeks at $735.37), pursuant to Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

4/16/19
Date

APR 17 2019

Steven Van Buren v. Meade Electric Co., No. 18 WC 002344

Preface

The parties proceeded to hearing February 26, 2019, on a Request for Hearing indicating the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to the injury; and what is the nature and extent of the injury. No transcript was ordered. Petitioner was the only witness. Arbitrator's Exhibit 1. Respondent called no witnesses and introduced no evidence.

Findings of Fact

Steven Van Buren (Petitioner), a 53 year old male, testified that on February 17, 2015, he was a crew foreman for a subcontractor (Respondent), working underground on a Commonwealth Edison project in Chicago expanding CTA tracks. He said he was digging, moving, and removing electrical lines. All the cables were energized. Petitioner testified he noticed an abnormality in the condition of the pipes in the trench, thought it dangerous and wanted the work suspended. It wasn't. He was wearing protective equipment including a helmet, suit and face covering. Petitioner's Exhibits 6d; 6e; 6f; 6g.

Petitioner testified he was using a hydraulic hammer and came in contact with a 12,000 volt energized pipe. The resulting explosion knocked Petitioner unconscious and back two to three feet. The flash from the explosion set his jumpsuit on fire and the flash burned his face, going under his mask. Petitioner's Exhibit 2 (unpaginated); Petitioner's Exhibit 6e.

Petitioner testified he regained consciousness. He said paramedics removed him from the scene and took him to the hospital. Petitioner testified his face was black, and he was in shock. He said, in essence, there was a profound emotional effect from the explosion and fire.

The records of Weiss Memorial Hospital indicate Petitioner was transported by the Chicago Fire Department to Weiss February 17, 2015, with an electrical burn. The emergency room chart indicated Petitioner suffered burns over his chin, left maxillary area, right TMJ and cheek, upper and lower lip, and left ear. The chart noted multiple burns over Petitioner's body. A physical examination of Petitioner's skin showed flash burns to Petitioner's chin and cheeks, mouth, lips and left ear. Petitioner's face was fully cleaned and debrided, and Silvadene cream applied. He was prescribed Norco and given Flouresoein eye strips, and Silversulfadiazine. The discharge record indicated a diagnosis of burns of the face, head and neck. Petitioner's Exhibit 2 (unpaginated).

During his testimony, Petitioner wept in describing the accident and treatment at Weiss. He told of asking someone to call his wife to tell her what happened.

Petitioner was instructed to and testified he did follow up with his primary care physician.

The records of Winters Family Practice indicate Petitioner was seen February 19, 2015, as an acute visit because of being burned at work. Petitioner sustained first and second degree burns to his nose, right ear, cheeks and chin. A physical examination revealed crusting of his ear, erythema of both sides of his face, crusting on his nose and lip. Dr. Gregory Winters indicated Petitioner would not be able to work until he was more healed. Petitioner's Exhibit 4 (unpaginated).

Petitioner testified he also sought treatment at Midwest Orthopaedics at Rush. The records of Midwest Orthopaedics indicate Petitioner was first seen February 19, 2015, for a burn to the face. He was diagnosed with a second degree burn to his face. Petitioner was prescribed Bacitracin. His work activity was restricted to indoor clean work, "no outside work or work in dirty environment." He was told to, and did, follow up on February 23, 2015. At that time, his diagnosis, work restrictions and medication remained the same. Petitioner's Exhibit 3 (unpaginated).

Petitioner testified he worked for Respondent for several more years back in the trenches. He testified of his apprehension on the job and how the explosion affected him. He testified the explosion and burn were the worst trauma he had ever encountered. Petitioner said, even four years later, he is startled by loud noises. Those noises take him back to the explosion and burn. Petitioner testified he now works for a different employer, a gas supplier, and is still a foreman for an underground crew. At this point, Petitioner testified he feels the cold to a greater degree than before he was burned.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill-being causally related to the injury. An injured employee bears the burden of proof to establish the elements of his right to compensation, including the existence of a causal connection between his condition of ill-being and employment. Navistar International Transportation Corporation v. Industrial Commission (Diaz), 315 Ill. App. 3d 1197, 1202-1205 (2002). A claimant must prove that some act or phase of employment was a causative factor in the injury. Vogel v. Illinois Worker's Compensation Commission, 345 Ill. App. 3d 780, 786 (2005). In Illinois, psychological injuries are compensable either under "physical-mental" when injuries are related to and caused by physical trauma or injury; or "mental-mental" when the claimant suffers a sudden severe emotional shock traceable to a definite time, place, and cause which causes psychological injury or harm though no physical trauma or injury was sustained. Chicago Transit Authority v. Illinois Worker's Compensation Commission, 2013 Ill. App. (1st) 120253 WC paragraph 17.

Here, there can be no dispute Petitioner suffered an actual physical trauma February 17, 2015, when an electrical explosion caused first, and second degree burns to his nose, ear, cheeks, and chin. This is no minor event. I rely on the testimony of Petitioner and the records of Weiss Memorial Hospital, Winters Family Practice, and Midwest Orthopaedics at Rush.

Petitioner testified as to the psychological result of the physical trauma, the re-experiencing his reaction to the explosion and burns. While there was no medical evidence of a psychological effect of the explosion and burns, a claimant's testimony, standing alone, may support an award where all of the facts and circumstances do not preponderate in favor of the opposite conclusion. Seiber v. Industrial Commission, 82 Ill. 2d 87, 97 (1980). Here, Petitioner's credible emotional testimony was uncontradicted, and not challenged at all.

I find, as a conclusion of law, Petitioner's current condition of ill-being is causally connected to the injury he sustained on February 17, 2015.

Disputed issue **L** is, what is the nature and extent of the injury. The injury suffered by Petitioner was both being burned on his face, head, and neck; and also suffering psychological trauma, most likely acute stress disorder.

Here, permanent partial disability is established using the criteria found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, this Arbitrator finds as follows.

With regard to subsection (i) of Section 8.1b(b), this Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Because of this, I give this factor no weight in determining the level of disability.

Regarding subsection (ii) of Section 8.1b(b), the occupation of the employee, I note at the time of the injury, Petitioner was the crew foreman for electricians working underground. He continues to work in the trenches, underground, and seems confronted by the same circumstances surrounding the accident and injury every time he goes to work, every time he hears a loud noise and re-experiences the explosion. I give this factor great weight in determining the level of disability.

Regarding subsection (iii) of Section 8.1b(b), this Arbitrator notes Petitioner was 53 years old at the time of the accident. He has many years to go in his field of work, and I give this factor weight in determining the level of disability.

With regards to subsection (iv) of Section 8.1b(b), Petitioner's future earnings, no evidence was offered on any effect to Petitioner's future earnings. I give no weight to this factor in determining the level of disability.

With regards to subsection (v) of Section 8.1b(b), evidence of disability corroborated by treating medical records, there is none. I give this factor no weight in determining the level of disability, but do not discount the psychological effect on Petitioner.

Based on the above factors, the testimony offered, and my reading and consideration of the record as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 10% (50 weeks) loss of a person as a whole pursuant to Section 8(d) 2 of the Act.

Thomas J. Cole

Arbitrator

4-16-19

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC006540
Case Name	DONALDSON, JENNIFER v. HALLCON CORPORATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0423
Number of Pages of Decision	18
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	William Lemp

DATE FILED: 8/20/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0423

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

Jennifer Donaldson,

Petitioner,

vs. NO: 19 WC 6540

Hallcon Corporation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and prospective medical treatment, and being advised of the facts and law, modifies the Arbitrator Decision and corrects a scrivener's error. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission solely seeks to correct a clerical error in the Arbitrator Decision. On page eight (8) of the Decision, the Arbitrator mistakenly wrote that the MRI of the cervical spine performed on December 27, 2018, showed disc herniation. This is a clerical error. The Commission thus modifies the above-referenced sentence to read as follows:

> An MRI of the cervical spine performed on December 27, 2018, showed **no** disc herniation and no significant spinal stenosis, but did show some disc desiccation and mild ridging from C1 through C7.

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 April 30, 2020, is modified as stated herein.

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

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.

August 20, 2021

o: 7/13/21
TJT/jds
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 21IWCC0423
NOTICE OF 19(b) ARBITRATOR DECISION

DONALDSON, JENNIFER
Employee/Petitioner

Case# **19WC006540**

HALLCON CORPORATION
Employer/Respondent

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

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

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

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

1241 LEMP & MURPHY PC
WILLIAM LEMP
8045 BIG BEND BLVD SUITE 202
WEBSTER GROVES, MO 63119

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)

JENNIFER DONALDSON
Employee/Petitioner

v.

HALLCON CORPORATION
Employer/Respondent

Case # **19** WC **6540**

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 **Dennis S. O'Brien**, Arbitrator of the Commission, in the city of **Herrin**, on **March 11, 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 cervical 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 30, 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 $**23,414.56**; the average weekly wage was $**450.28**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **no** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services provided through date of arbitration..

Respondent shall be given a credit of $**21,313.49** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**21,313.49**.

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

ORDER

The Arbitrator finds that Petitioner's current condition of ill-being, discogenic neck pain, cervical disc herniation, and cervical annular tearing of the C4/5 and C5/6 discs is causally related to the accident of October 30, 2018. The Arbitrator further finds that the recommended treatment of C4/5 and C5/6 arthroplasty is reasonable and was necessitated by the accident of October 30, 2018.

Respondent shall authorize the C4-5 and C5-6 arthroplasty surgery recommended by Dr. Rutz and is responsible for all medical charges associated with that surgery and ancillary medical treatment relating to that surgery, subject to the medical fee schedule.

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

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

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

Signature of Arbitrator

April 23, 2020
Date

ICArbDec19(b)

APR 30 2020

Findings of Fact

This hearing was for two purposes, to determine causal connection for Petitioner's cervical spine condition, causal connection having been accepted by Respondent in regards to right arm, knee and low back conditions of ill being, and, if so, to determine whether a two-level cervical disc replacement surgery recommended by Dr. Rutz was reasonable and necessary.

Testimony at Arbitration

Petitioner testified that on October 30, 2018 she was employed by Respondent driving railroad employees to where they needed to go. She said she worked different hours and was on call 24/7. She said that shortly after midnight on October 30, 2018 she was on her way back from Fulton, Kentucky, having dropped a man off there, and she was beginning to get drowsy. It was her intention to pull over at the next stop, but she did not make it to the next stop. She said she saw the vehicle swerving, saw a sign coming towards her, and she turned. The next thing she knew she was in a ditch with glass and blood all over her. She said she was banged around as the seat belt did not lock, tighten, or hold her in place and the air bag had not deployed. She said the sign had entered the vehicle through the windshield and was laying in the seat. She said Petitioner Exhibit 17 showed the damage done by the sign.

Petitioner said that following the accident she experienced pain in various parts of her body. Petitioner said that the problems in areas noted on her Application for Adjustment of Claim, her right shoulder, her arm and her low back had not resolved, she still had issues with a couple parts of her body. She said her main issues as of the date of arbitration were her neck, left arm, and right arm, with the neck being the worst.

Petitioner testified that immediately after the accident she went to Marion Memorial Hospital, receiving follow up care from Heartland Regional Medical Center, SIH WorkCare, and Dr. Miller, as well as receiving physical therapy. She said she also underwent testing to her neck and shoulders. She eventually came under the care of Dr. Rutz and was examined at Respondent's request by Dr. Wayne.

Petitioner noted that as of the last time she had seen him, Dr. Rutz was recommending surgery to her neck.

Petitioner said that prior to this accident she had received treatment to her neck as a result of a car wreck she had been in at age 18. She said she had experienced cervical complaints on and off since that time. The treatment she had previously received included the prescription of pain medication and chiropractic therapy. The last time she had received treatment to her cervical spine prior to this accident was a year or two earlier. She said that no doctor had advised her that she needed surgery prior to this accident.

Petitioner said that she had not experienced any additional accidents involving her cervical spine between the date of this accident and the arbitration date.

Petitioner said that her goal as a result of the arbitration hearing was get back to work and to get better, as she was tired of having headaches daily and of her arm and neck hurting.

On cross-examination Petitioner testified that she was still an employee of Respondent to the best of her knowledge, that while she was not working, she was receiving temporary total disability benefits. She said it was her intention to eventually return to work for Respondent. She said at the time this accident occurred she was a new employee with Respondent, having started on August 17, 2018.

Petitioner said that the automobile accident when she was a teenager resulted in intermittent treatment to her neck and low back. She said at the present time she was not claiming any need for medical treatment for her low back as a result of the accident of October 30, 2018.

Petitioner testified that she had seen an orthopedist, Dr. Davis, who had told her that surgery to her right shoulder was a possibility.

She said that when she was examined by Dr. Wayne, he talked to her about her right shoulder problems and that he recommended right shoulder surgery. When asked if she had received follow up care from anyone for her right shoulder Petitioner said Dr. Rutz told her that no one would look at her arm until after treatment of her neck was finished, and the doctor she was supposed to see for her arm would not make an appointment for her until after she was done with the neck.

Petitioner said she went to see Dr. Rutz after her attorney gave her that physician's name.

Petitioner said she knew Dr. Rutz was recommending a two-level cervical disc replacement, saying he had not told her whether that was an FDA approved procedure, they had never discussed that. When asked if Dr. Rutz had discussed the risks and benefits of that surgery Petitioner said he had, that he told her should be a great surgery, that she would be released right afterwards and that she couldn't hurt it. She said he did not tell her of any risks associated with the procedure.

Petitioner said she saw Dr. Apostol on June 27, 2016, more than two years prior to this accident, and that she told him at that time of having chronic neck and back pain from the auto accident when she was 18. She said she would have been 42 years old at the time of that visit with Dr. Apostol. She agreed that at that time she told him her neck was worse, to the point where she was not able to do her activities. She said that at that time Dr. Apostol recommended she be referred to a specialist in Carbondale, Dr. Smith. She said she believed she saw Dr. Smith twice, and that he ordered a CT scan which was performed on July 30, 2017. She did not think she took a copy of the CT scan with her to the appointment with Dr. Rutz. She was not aware of any comparison being made between the CT scan of July 30, 2017 and the CT scan which was performed after her work-related accident of October 30, 2018.

Petitioner said the discogram performed by Dr. Rutz was painful, and the pain differed, with it being extremely bad when he put the needle in a certain spot. Petitioner said that while she had a 26 pack year history of smoking she had quit smoking December 19, 2017 and had not smoked for over two years.

Petitioner testified that she remembered a lot of what happened in regard to the accident of October 30, 2018, including most of the ambulance ride. She was pretty sure she told the ambulance crew what parts of her body she injured and that the main problem she spoke of was in regard to her right shoulder, with significant bruising to the right shoulder. She said she had no problems in regard to her right shoulder prior to the accident. She said her left shoulder had a different type of pain, the pain runs from the neck down the arm, while the right shoulder hurts when she moves it in certain ways, it would pop and hurt a great deal.

Petitioner agreed that she had undergone an MRI of her right shoulder and spoke with the doctors about its findings. She said their recommendation for surgery was based on the right shoulder MRI findings. She said she had undergone an MRI to her cervical spine and she believed she had one for her left shoulder as well. She said she did not know what the radiologist who interpreted the MRI interpreted in regard to the cervical spine MRI.

She said she spent some time giving Dr. Wayne her history and being examined by him. She said he was pleasant to her.

Petitioner said that in 2016 she saw Dr. Smith twice for her symptom flare-up from her earlier vehicular accident. She said earlier she had received chiropractic therapy from Dr. Kent Herron, in West Frankfort, Illinois. She said he had been her chiropractor since she was 18. She said that while he was still in business she had not seen him in years, she could not remember her last visit with him. She said she had not seen him since October 30, 2018, nor had she seen any other chiropractors.

On redirect examination Petitioner's attorney asked her if she would have any reason to disagree with Dr. Rutz's records if they reflected that he had explained the risks and complication of the planned surgery, and she said she did not.

On recross examination Petitioner said she could not remember what the complications might be, she just remembered she wanted the surgery performed. She could not remember if Dr. Rutz told her what could go wrong with the surgery.

Medical Evidence

Pre-accident medical records were introduced by Respondent. Petitioner saw Dr. Apostol on June 27, 2016 as a new patient transferring from another physician. She advised Dr. Apostol that her main concern was her chronic back pain and neck pain, which she noted was from her motor vehicle accident at age 18. She advised him she had seen a chiropractor and had taken pain medication in order to function, but that her neck and back pain was getting worse to the point that she was not able to do her activities, and she was requesting a referral to a spine specialist. Dr. Apostol noted that he did not do pain management but would be sending Petitioner to a spine specialist and, if needed to a pain specialist. RX 2

There were no additional medical records introduced for medical treatment from June 27, 2016 until January 5, 2018 when Petitioner advised Dr. Apostol that she had recently been hospitalized for pneumonia and respiratory failure, gradually improved and was discharged in stable condition. She noted that she had been very anxious, had lost her car and house and had other personal problems. She was physically examined on that date and was found to have intact range of motion and no abnormalities were identified. Dr. Apostol's assessment on that date was pneumonia of the lower lobe due to an infectious organism. No complaints or physical findings in regard to Petitioner's neck, back, shoulders or arms are included in the records for that visit. RX 2

Between January 8 and January 17, 2018 Petitioner had several telephone conversations with Dr. Apostol's office staff in regard to weakness, shakiness and nausea and a yeast infection and a request for a Norco refill, with the note that the Petitioner had been prescribed 30 Norco upon recent discharge from her pneumonia hospitalization. Petitioner was seen by Dr. Apostol's partner, Dr. Ali, advising him that her respiratory symptoms, shortness of breath and fatigue were significantly improved. He also noted at that time that "patient also has chronic back pain." His only diagnosis at that visit was pneumonia of both lungs due to an infectious organism and his treatment recommendation was to continue her inhaled medications. RX 2

Petitioner continued getting home health care and was in contact with Dr. Apostol's office from January 31, 2018 through February 5, 2018 for problems relating to her lungs and edema. Petitioner was not seen or in telephone contact with Dr. Apostol's office subsequent to February 5, 2018. RX 2

No medical records were introduced into evidence for the period between February 5, 2018 and the date of this accident, October 30, 2018, a period of nearly nine months.

On the date of this accident, October 30, 2018, Petitioner was taken by Johnson County Ambulance from the site of her motor vehicle accident to Heartland Regional Medical Center. She gave a consistent history of falling asleep and running off the road to the ambulance crew, telling them that she hurt "all over," and that a mile marker sign entered her vehicle and struck her in the right arm and shoulder area. They noted moderate bruising and swelling to the right arm and shoulder area, with pain upon movement of the right arm. PX 3

When seen at Heartland Regional Medical Center immediately after the accident Petitioner was found to have sustained "neck injury, pain, injury to the chest, contusion." He main complaints were recorded as right shoulder and knee pain, however. A physical examination at that time revealed full range of motion of the low back, with no spinal tenderness, mild neck tenderness in the left mid cervical area and the right mid cervical area as well as abrasions and contusions to the right shoulder and knee, with decreased range of motion. CT scans taken on the day of the accident of the head, chest and abdomen, and pelvis were interpreted as normal while the CT scan of the cervical spine showed straightening of the spine was identified and early degenerative changes were noted. X-rays of the right knee showed no abnormalities. No CT scan of the right shoulder was ordered. PX 4

Petitioner was seen in follow up at SIH Workcare by Dr. Sullivan on November 1, 2018. She was complaining of headache, neck pain, dizziness, blurred vision, balance issues, sensitivity to light and sound as well as in regard to her chest/middle back, right shoulder, right arm, and the right upper leg/knee. Petitioner reported that she had lower cervical spine pain which was constant and became worse with movement of the neck. She told Dr. Sullivan that she had prior low back pain and that it had not increased. The physical examination on that date revealed tenderness over the lower midline of the cervical region, tenderness on the left side of the paraspinal area, tenderness over the left trapezius, tenderness and limited range of motion of the right shoulder, with swelling and bruising over the entire right shoulder area as well as tenderness over the medial femoral/tibial condyle of the right knee. Dr. Sullivan's diagnoses on November 1, 2018 were concussion, cervicalgia, contusions of the right upper arm, breast, and chest wall as well as pain in the thoracic spine, the right shoulder, arm, elbow, wrist and knee. She restricted Petitioner from work at that time. PX 5

Dr. Sullivan's office notes for November 5, 2018 contained similar complaints and findings, and note her review of the radiology images from the emergency room. She ordered a doppler study of the swollen and bruised right arm and the test that day found Petitioner's blood vessels were normal with no evidence of a DVT. PX 5

On November 7, 2018 Petitioner advised Dr. Sullivan that her concussion symptoms were improving but her neck and right shoulder pain continued. Her lumbar pain continued, but was improved. Her physical exam on that date showed her cervical range of motion was limited due to pain and her right shoulder exam was also limited due to pain. Dr. Sullivan continued to restrict Petitioner from work. She then referred Petitioner to Dr. Miller for an evaluation of the large hematoma in the right upper arm. PX 5

Dr. Miller saw Petitioner on November 13, 2018. He noted pain complaints in the right upper arm and shoulder, as well as headaches, neck pain and weakness. He noted that Petitioner also told him of chronic back pain. His examination found Petitioner's cervical region normal and found the right shoulder to have edema, tenderness and pain, decreased range of motion and normal strength. He did not recommend any surgical treatment for the right arm hematoma, but instead felt continued observation for changes was appropriate, with Petitioner to return if it worsened, but further advised her that it could take 3 to 6 months for the hematoma to absorb. PX 5

An MRI of Petitioner's right shoulder was performed on November 16, 2018 which revealed severe supraspinatus tendinosis with small partial-thickness tearing of the anterior insertional fibers. It also showed bursal surface fraying and a partial-thickness tear of the bursal surface and marked subscapularis tendinosis with moderate infraspinatus tendinosis, posterior labrum intrasubstance degeneration and/or superimposed small tear, severe glenohumeral joint osteroarthritis and degenerative changes of the AC joint. PX 5/PX 6

Petitioner received physical therapy from November 16, 2018 through November 28, 2018 which showed some improvement in her low back but continued severe pain in her neck, right shoulder and right upper arm. PX 8

On November 28, 2018 Dr. Sullivan noted that Petitioner felt her concussion was doing much better, that she was only suffering from minor headaches, occasional dizziness and some memory and concentration problems. She was also complaining of 7/10 neck pain, and 7-8/10 right shoulder pain. Her physical examination of that date showed little in regard to the low back, tenderness over the left lateral lower cervical and bilateral trapezius regions and her usual right shoulder findings. Dr. Sullivan gave her restrictions for work of lifting less than 5 pounds, working 4 hours per day, and no driving or reaching away from her body. She was referred to an orthopedist at that point for her right shoulder and it was noted that due to her concussion she would have to be cleared by a neurology consult for her to drive. PX 5

Petitioner was seen by Physicians Assistant Palmer at the Orthopaedic Institute of Southern Illinois on November 29, 2018. Her right shoulder pain at that time was 7/10 and on physical examination he found ecchymosis to be resolving in the front of her mid arm, with tenderness present, a tender AC joint, slightly reduced strength and range of motion of the shoulder, and reduced rotator cuff strength. He felt her prior MRI had shown an incomplete rotator cuff tear, and a contusion of the deltoid muscle with a likely partial thickness tear that was responsible for her hematoma. He diagnosed a traumatic hematoma, a tear of the deltoid muscle and an incomplete tear of the right rotator cuff. He ordered an MRI, injected her subacromial space, prescribed Norco, restricted her from work and noted that her injuries were causally connected to the accident. PX 9

When seen by Dr. Sullivan on December 6, 2018 Petitioner said her neck pain was 5/10, mostly in the lower neck and lateral left side of the neck and she was having occasional numbness and tingling in both hands. The doctor noted that Petitioner had not reported that in the past in regard to the left side, but had in regard to the right side. The physical examination on that date showed the low back to have no pain and a full range of motion, pain along the left trapezius area and the lateral lower neck and full range of motion of the neck, but with pain with flexion and turning to the right. PX 5

An MRI of Petitioner's right humerus was performed on December 18, 2018. It showed a well defined collection of fluid and edema in a tract within the subcutaneous soft tissues which could possibly represent a focal abscess. The humerus itself was felt to appear normal. PX 10

Petitioner was seen by Dr. Davis at the Orthopaedic Institute of Southern Illinois on December 20, 2018. At that time Petitioner was continuing to have lateral based shoulder pain, lateral brachial pain, paracervical tenderness to palpation, and radiation down the tops of both the left and right arms. Petitioner's physical examination on that date showed a limited lateral bend and mildly positive Spurling's maneuver on the right side of her neck and full strength in all muscle groups. Dr. Davis diagnosed a right shoulder traumatic rotator cuff tear, partial traumatic deltoid tear and a cervical disk bulge with possible herniation. Dr. Davis felt that the previous MRI of the deltoid was of poor quality so he ordered an new MRI, and stated that what type of surgery would be necessary would depend on the results of that MRI. Dr. Davis stated that in regard to her neck, "she is having intractable pain, had over 6 weeks of therapy and treatment, is tired of living with this condition. We are going to obtain an MRI scan and have her see one of our neck specialists." PX 9

An MRI of the cervical spine performed on December 27, 2018 showed disc herniation, no significant spinal stenosis but did show some disc desiccation and mild ridging from C1 through C7. PX 5/PX 6

Dr. Sullivan saw Petitioner on December 31, 2018. Petitioner at that point was complaining of neck pain of 3-4/10, located on the left side of the neck and the trapezius. Dr. Sullivan noted that the recent MRI showed no severe foraminal or central canal narrowing and no disc herniation, and that Dr. Davis had referred Petitioner to Dr. Sinha for treatment of the spine. Because Dr. Davis and Dr. Sinha were to treat Petitioner's right shoulder and neck Petitioner was discharged at that time from Workcare. PX 5

Petitioner saw Physicians Assistant Reed on January 11, 2019 with continued right shoulder complaints. The records for that visit reflect Petitioner stating that she had not had the right arm MRI, though Petitioner's Exhibit 10 is dated December 18, 2018 and is a radiology report for an MRI of the humerus. PA Reed also saw Petitioner on that same date in regard to her cervical spine. Pain was reported to be 7/10 and aggravated by extension and flexion. The physical exam that day showed tenderness in the lower cervical region at the midline and on the left as well as to the left trapezius region. She was especially tender with the turning of her head to the left. The earlier cervical MRI was interpreted at this time as showing a small foraminal disc which caused mild foraminal stenosis at C5/6 and C6/7. A cervical steroid injection was prescribed as well as physical therapy for the neck. PX 9

On January 16, 2019 a second MRI of the humerus occurred and only reported trace right elbow effusion and no acute fracture of the right humerus. PX 10

On January 28, 2019 Petitioner was seen for a spinal consultation by Nurse Practitioner Vandergriff. On the history form filled out by Petitioner for that appointment Petitioner wrote, "I've had some problems for years but not this bad. I'm in tears a lot." The nurse practitioner's notes state, "Prior to her accident she has had previous issues with her neck for the last 15 years or so. * * * Since her accident, she has been experiencing more constant and severe pain in her neck and it is accompanied with frequent posterior headaches. She experiences pain and paresthesias into her shoulders and throughout her bilateral upper extremities and into her hands." The physical examination on that date revealed a decreased cervical range of motion for flexion and extension, motions which reproduced Petitioner's neck pain. NP Vandergriff's assessment at that time was cervical radiculopathy, cervical stenosis and cervicalgia. He ordered a better MRI of the neck to assess stenosis. He also restricted Petitioner from work. PX 12

The cervical MRI of February 15, 2019 was interpreted by the radiologist as showing a possible small left foraminal protrusion at C3/4 which resulted in a mild degree of left foraminal stenosis, a possible small right foraminal protrusion and perhaps a small left foraminal protrusion at C4/5 with mild bilateral foraminal stenosis, and a left lateral recess protrusion extending into the left foramen at C5/6, with probable moderate left foraminal stenosis. PX 13

On March 3, 2019 Dr. Schoen performed an epidural steroid injection at C5/6 on the right. PX 13

Petitioner was seen by Dr. Rutz on May 19, 2019. Her complaints at that time were of persistent neck pain, worse on the left than on the right, with some pain, numbness and tingling into the left greater than the right arms. She said the C5/6 epidural had not helped. Dr. Rutz's interpretation of the most recent MRI was of mild disc degeneration at C4/5 and a small left sided disc protrusion at C5/6. Dr. Rutz was of the opinion that Petitioner had cervicalgia with radiculopathy. He noted that if Petitioner was interested in surgery he would require discography from C3 to C7 to rule in or out the changes seen on the MRI. PX 12

Dr. Rutz saw Petitioner for a second time on June 11, 2019. Petitioner was at that time concerned about a painful lump on the back of her neck which had been present since the time of her epidural steroid injection. During his examination Dr. Rutz noted a significant amount of adipose, fatty tissue in the neck area as well as diffuse tenderness of the posterior neck and over the left trapezius. He ordered a new MRI of the cervical spine which was to include the posterior soft tissues and subcutaneous tissues to rule out a hematoma or an abscess from the epidural steroid injection. PX 12

An MRI was conducted on June 11, 2019 which noted shallow central disc bulges at C4/5 and C5/6 without significant cord deformity, or central or foraminal compromise. PX 13

Discograms were conducted on June 27, 2019. The radiologist noted that Petitioner had concordant pain responses at C4/5 and C5/6 with extravasation of contrast at those levels. He noted discography was negative at C6/7. PX 14

Following the discograms Dr. Rutz saw Petitioner on July 9, 2019. He noted the concordant reproduction of symptoms at C4/5 and C5/6 in the discograms. Petitioner advised him she wanted definitive care and surgery involving C4/5 and C5/6 anterior cervical diskectomies and total disc arthroplasties was therefore planned. PX 12

Testimony of Dr. Kevin Rutz

Dr. Rutz testified for Petitioner by deposition. He described his orthopedic practice as specializing in spinal surgery, noting that he had been performing cervical disc arthroplasties, disc replacements, for five years, having performed approximately 600. He felt that type of surgery was preferable in many instances as it resulted in less postoperative pain, a faster return to work, and patients couldn't "screw it up." PX 15 p.4,6 He described the findings of himself and his nurse practitioner in a manner consistent with his medical records. He noted that Petitioner told him that she had neck problems over the prior 15 years but that those problems had improved with physical therapy. She further advised him that her neck symptoms had become more severe following this accident with frequent headaches and bilateral radiculopathy. PX 15 p.8-13

Dr. Rutz testified that in his opinion a person can have an injury to a disc that causes symptoms, as opposed to radiculopathy or stenosis causing the symptoms. He said that the treatment for a disc causing symptoms can be either nonoperative or the type of surgery he was recommending. He said he had been pleased with the results from this type of surgery for this type of problem, noting that on the day prior to his deposition he had performed such a surgery and his patient's headache was gone immediately following the surgery. PX 15 p.15,16

When asked if the motor vehicle accident of October 20, 2018 could have caused or aggravated Petitioner's cervical spine condition, Dr. Rutz stated that Dr. Cizek had found tears in the back of the C4-5 disc and the C5-6 disc that reproduced Petitioner's neck pain and that the discograms performed by Dr. Cizek confirmed what he suspected, that based upon the Petitioner's mechanism of injury and the MRI, she had torn her disc and that was what was producing her neck pain. PX 15 p.18,19

Dr. Rutz disagreed with Dr. Wayne's diagnosis of a cervical sprain/strain as the problem's length of time extended past that of a sprain/strain. Dr.Rutz said that he and Dr. Wayne were of two different schools of thought, Dr. Wayne did not believe Petitioner was a surgical candidate as she did not have a nerve impingement type problem while Dr. Rutz said he was of the other group, that believed the structural injury to the disc giving headaches and pain should be considered for surgery, that Petitioner would have a good prognosis if she had the surgery. PX 15 p.21-24

On cross-examination Dr. Rutz testified that Petitioner had been referred to him by her attorney. He said he did not have Petitioner's medical records for prior to the accident. He agreed that the MRIs did not show any nerve root impingement and that he agreed with Dr. Wayne that there was no cervical radiculopathy seen. He said he felt discography was helpful in whiplash-type injuries with hyperflexion and hyperextension of the neck and a good chance of disc injury, and when asked if discography, which involves injecting dye into the disc and pressurizing it would injure the disc, noted that a small gauge needle was used, and he was unaware of a cervical discogram causing an injury, though it commonly caused pain as it was an uncomfortable test which could cause flareups of pain. PX 15 p.26-31

Testimony of Dr. Andrew Wayne

Dr. Wayne testified for Respondent by deposition. He noted that his review of the cervical MRI of February 15, 2019 showed diffuse degenerative changes, chronic appearing changes from C4 down to C7, with no major stenosis or compression of her spinal cord, and no herniated discs. RX 1 p.13

Dr. Wayne was of the opinion that Petitioner sustained a thoracic sprain and strain injury as a result of this accident with no acute abnormalities in the cervical spine. He did not believe she was a surgical candidate for any part of her body other than her right shoulder, which he believed was in need of surgical treatment as he did not see evidence of radiculopathy or nerve compression and the imaging studies did not reveal anything of a surgical nature in her cervical spine. He felt her neck should be treated conservatively with a TENS unit, topical creams like Icy Hot, Salon Pas patches, etc. RX 1 p.20-23

He testified that he did not believe the discograms of Petitioner showed concordant pain when performed, saying that they reproduced pain in the neck and down the left arm, while the records showed the majority of her radiating pain was not only in the neck but really down the right arm. He did not believe a two-level disc replacement in the cervical spine was necessary or prudent. He agreed that he was a physiatrist and not a surgeon and had never performed surgery. RX 1 p.31-33

Dr. Wayne on cross-examination said he felt the disc protrusions seen on the February 15, 2019 MRI were "more chronic-appearing disc bulges as opposed to being protrusions," but he went on to state that they did result in some dural displacement and probable mild left foraminal stenosis. He also agreed that he could not date the finding on the MRI, pinning them down to a week or a month, but he felt they appeared to be at least more than a year old. He said a motor vehicle accident could cause or aggravate a disc protrusion and that a disc protrusion can be painful. RX 1 p.41,42

Dr. Wayne said he disagreed with both the radiologist and Dr. Rutz in their opinions that Petitioner had a concordant pain reaction to the discograms. RX 1 p.44

Dr. Wayne felt that putting a large needle into a disc could traumatize and damage the disc, making it more prone to herniations. He said it had been shown that discogram findings did not necessarily correlate with a person being a good surgical candidate. He felt Petitioner had a cervical sprain/strain which had been caused by the motor vehicle accident, and that it would benefit from additional conservative care. RX 1 p. 45,50

Dr. Wayne said he did not believe Dr. Rutz's opinion on how to treat a disc injury where there was no evidence of radiculopathy was unreasonable, saying he just respectfully disagreed with that opinion. He said it was common for doctors to disagree and there was nothing inherently unreasonable about either of their positions. He agreed that conservative treatment had so far not improved Petitioner's condition. RX 1 p.51,52,55

On re-direct examination Dr. Wayne stated that during his examination of Petitioner she did not make any complaints in regard to her left shoulder, arm, or hand, including numbness or tingling. RX 1 p.60

On re-cross examination Dr. Wayne agreed that Petitioner had filled out a history form when she saw him and that in the pain diagram that she filled out she noted pins and needles sensations and aching sensation in both of her shoulders, numbness and pins and needles sensation in both of her hands and wrists as well as in her right shoulder. RX 1 p.62,63

Arbitrator's Credibility Assessment

The Arbitrator found Petitioner's testimony to be accurate and truthful. It was consistent with almost all of the medical records, with no glaring contradictions. While the arbitrator was not present at the depositions, he also finds that both Dr. Rutz and Dr. Wayne appeared to have testified truthfully, they are just of differing medical opinions.

Conclusions of Law

In regard to whether Petitioner's current condition of ill-being in regards to her cervical injury is causally related to this accident, and in regard to whether the prospective medical services that are sought by Petitioner are reasonable and necessary and whether Respondent should pay all appropriate charges for said medical services, the Arbitrator makes the following findings:

The findings in regard to credibility of witnesses and accident, above, are incorporated herein.

Prior to the date of this accident, October 30, 2018, Petitioner testified that she had experienced neck symptoms and had received medical treatment to the neck as a result of a motor vehicle accident which occurred when she was 18 years of age, 26 years prior to this accident. She said she had suffered neck complaints off and on since that time and had received treatment which included prescription pain medication and chiropractic care. She testified that prior to the October 30, 2018 accident she had last received treatment to her cervical spine a year or two earlier, and that no physician had ever recommended surgery prior to October 30, 2018. No medical records were introduced indication surgery had been recommended prior to October 30, 2018.

Some limited medical records for treatment received prior to October 30, 2018 were introduced into evidence, those being the medical records of Dr. Apostol, Petitioner's primary care physician, his partner, Dr. Ali, and their staff, for the period of time from June 27, 2016 through February 5, 2018. RX 2 The oldest record introduced was for Dr. Apostol's initial visit with Petitioner on June 27, 2016, 28 months prior to the October 30, 2018 accident. He was taking over care from Renee Kolman on that date. Petitioner gave him a history including chronic back and neck pain since a motor vehicle accident at age 18, and said it was getting worse to the point where she could not do her activities. She wanted to see a spine specialist. No physical examination of her neck was conducted at that time. Dr. Apostol noted he was going to refer her to an orthopedist for her neck pain. RX 2 Petitioner testified she believed she saw Dr. Smith twice, and that he ordered a CT scan which was performed on July 30, 2017. Neither Dr. Smith's records nor the radiology report were introduced into evidence by either party.

No medical records were introduced for the period from June 27, 2016 until January 3, 2018, a period of 18 months. The records for June 3, 2018 through February 18, 2018 all appear to be in regard to follow up treatment from a hospitalization in the days prior to January 3, 2018 for pneumonia and respiratory failure. The only relevant notations in those records are a note of January 18, 2018 by Dr. Ali, who was seeing her for

shortness of breath and fatigue, that "patient also has chronic back pain." No mention of cervical complaints is made in any of the office visits or telephone calls during that one-and-a-half month period. RX 2

There are no medical records for the period from February 5, 2018 until the date of accident, October 30, 2018.

The vehicular accident of October 30, 2018 was obviously quite severe. This is evidenced not only by Petitioner's testimony and the photograph of the vehicle where the sign entered the front seat through the windshield and struck her right shoulder, but also by the visible physical injury to Petitioner's right upper arm, which suffered a severe hematoma and swelling which persisted for a lengthy period of time and resulted in internal structural damage to the upper right arm and shoulder.

Following the motor vehicle accident of October 30, 2018 Petitioner was treated in the emergency room and complaints were made in regard to the right arm, shoulder, and knee as well as neck pain with movement. The physical examination on the date of the accident included the finding of neck tenderness in the left mid cervical area and the right mid cervical area. PX 4

In follow up care with Dr. Sullivan, Petitioner on November 1, 2018 complained, among other things, of headache, neck pain, and lower cervical spine pain, which was worse with moving of the neck. Petitioner had similar neck complaints when seen by Dr. Sullivan on November 5, 2018 and November 7, 2018. On the latter date it was noted Petitioner's cervical range of motion was limited due to pain. Petitioner was still making neck complaints when seen by Dr. Sullivan on November 13, 2018. PX 5

Petitioner received physical therapy to her neck from November 16, 2018 through November 28, 2018, and on that last date her neck pain was still described as severe. PX 8

During Dr. Sullivan's office visits with Petitioner on November 20, 2018, November 28, 2018 and December 6, 2018 Petitioner continued to make complaints of neck pain, including pain of 7/10 on the lateral left lower neck and into bilateral trapezius. On that last date her physical examination revealed tenderness over the left lateral lower cervical area and pain with range of motion. On December 6, 2018 her neck pain was still 5/10 and she was noting occasional numbness/tingling in both hands. The doctor noted she had made that complaint in regard to the right hand previously but the left hand symptoms were new. It was also noted that that physical therapy to the cervical region had actually increased Petitioner's pain into the right shoulder, so the cervical therapy had been stopped. Another MRI of the neck was ordered at that time. PX 5

The MRI was performed on December 27, 2018 and Dr. Sullivan at her next follow up on December 31, 2018 noted that the neck pain continued but the MRI showed no severe foraminal or central canal narrowing and no disc herniation. PX 5

Petitioner was referred to Dr. Sinha for her neck problem and was seen by Physician Assistant Reed for a cervical spine consult on January 11, 2019. At that time she had left and right sided neck pain which radiated from the right side of the neck greater than from the left side of the neck. The pain was aggravated by extension and flexion and the neck was tender in the lower cervical area at the midline and on the left. A cervical steroid injection was ordered as was physical therapy. PX 9

Petitioner was seen by Nurse Practitioner Vandergriff for her neck complaints on January 28, 2019 and noted on her history form that she "had some problems for years but not this bad. I'm in tears a lot." Her pain drawing indicated pain was 6/10. The office notes for that visit indicate, "Prior to her accident she has had previous issues with her neck for the last 15 years or so. * * * Since her accident, she has been experiencing more constant and severe pain in her neck and it is accompanied with frequent posterior headaches. She experiences

pain and paresthesia's into her shoulders and throughout her bilateral upper extremities and into her hands." The assessment on that date was cervical radiculopathy, cervical stenosis and cervicalgia. PX 12

A cervical MRI on February 15, 2019 showed possible small protrusions at C3/4, C4/5 and C5/6 with varying degrees of foraminal stenosis. PX 13

When seen for her neck by Dr. Rutz on May 19, 2019 Petitioner was complaining of neck pain which was greater on the left than on the right. Dr. Rutz diagnosed cervicalgia with radiculopathy and noted that discograms would have to be performed if Petitioner was interested in surgery. PX 12

An MRI of the cervical spine on June 11, 2019 was interpreted to show disc bulges at C4/5 and C5/6. PX 13

Discograms of C4/5 and C5/6 were interpreted as showing concordant pain response while C6/7 was considered negative for a concordant pain response. PX 14

On July 9, 2019 Dr. Rutz, after reviewing the discogram results recommended C4/5 and C5/6 disc replacement surgery. PX 12

Causal connection and necessity for the disc replacement surgery could be found based upon the medical evidence noted above on a chain of events theory. Chain of events causality requires three things, a previous condition of good health, an accident, and a subsequent injury resulting in disability. International Harvester v. Industrial Commission, 93 Ill. 2d 59, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982) While Petitioner had chronic neck complaints for approximately 26 years prior to the date of this accident, and had received chiropractic care and pain medication as it intermittently caused her problems, the last medical complaints evidence by medical records date back to June of 2016, 28 months prior to this accident. While she was asking to see a specialist at that time as the pain had gotten worse, no medical records for subsequent medical care was introduced into evidence. Petitioner did testify that she saw a specialist, Dr. Smith, on two occasions, and that a CT scan was performed in July of 2017, but again, no records for that were introduced. That CT scan would have been approximately 15 months prior to this accident, and there is nothing to reflect ongoing neck problems in need of treatment in the year or more prior to this accident. This constitutes proof of good health prior to the accident in question.

Further, Petitioner meets the "proof of good health" requirement despite her having suffered chronic back and neck pain for 26 years since a motor vehicle accident at age 18. This principle is one of common sense, for "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 vs. Illinois Workers' Compensation Commission, 2017 ILL.App. (4th) 160192WC ¶26. The Appellate Court in that case went on to note that the Supreme Court in International Harvester found that the chain of events theory for causation applied even though, "in that case the claimant's health was anything but good. In fact, the claimant was injured when he violated a work restriction that was imposed following an earlier surgery." Schroeder vs. Illinois Workers' Compensation Commission, Id at ¶27.

The second requirement, an accident, is not disputed in this case. The accident was quite traumatic, as shown by the photograph of the vehicle indicating the force and location of the sign which entered Petitioner's vehicle and the extent of physical injury to Petitioner's right upper arm.

The third requirement, a subsequent injury resulting in disability is proven by the immediate and continual cervical complaints and findings in the months following this accident, described above. Petitioner advised her

treating physicians that she had prior complaints since the age of 18 while also noting that this accident had aggravated them a great deal, causing her to receive months of conservative treatment, including physical therapy which further aggravated her cervical symptoms. As Petitioner noted to Nurse Practitioner Vandergriff, she "had some problems for years but not this bad. I'm in tears a lot." PX 12 It was only after this accident that a surgical recommendation was made.

As noted above, the Arbitrator finds Petitioner's testimony, including her history of complaints both before and after this accident, to be credible. Petitioner has thus introduced sufficient evidence to prove the requirements of a chain of events causal connection.

But in addition to a chain of events finding of causal connection, the medical opinions of her treating surgeon, Dr. Rutz, also support such a finding. Dr. Rutz stated that Dr. Cizek had found tears in the back of the C4/5 disc and the C5/6 disc that reproduced Petitioner's neck pain and that the discograms performed by Dr. Cizek confirmed what he suspected, that based upon the Petitioner's mechanism of injury and the MRI, she had torn her disc and that was what was producing her neck pain. PX 15 p.18,19

Dr. Rutz testified that his diagnosis for Petitioner was discogenic neck pain, cervical disc herniation and cervical annular tears. Dr. Rutz recommended C4/5 and C5/6 disc arthroplasty to treat Petitioner's persistent symptoms. He said he did not believe she would improve without that surgery, noting that in almost a year of conservative treatment she had not improved. PX 15 p.19

Respondent's §12 examiner, Dr. Wayne, did not agree with Dr. Rutz's diagnosis or what was causing Petitioner's complaint, instead thinking Petitioner was merely suffering from a cervical sprain/strain, Dr. Wayne said he disagreed with both the radiologist and Dr. Rutz in their opinions that Petitioner had a concordant pain reaction to the discograms. Dr. Wayne said he did not believe a two-level disc replacement in the cervical spine was necessary or prudent. Dr. Wayne felt additional conservative treatment, such as the use of a TENS unit, topical creams like Icy Hot or Salon Pas patches would be appropriate. He agreed that he was a physiatrist and not a surgeon and had never performed surgery. RX 1 p.20-23,31-33,44

Dr. Wayne felt that the discogram could itself traumatize and damage the disc, making it more prone to herniations, as the test involved putting a large needle into the disc. RX 1 p.45 Dr. Rutz contradicted Dr. Wayne in that regard, stating that a small gauge needle was used in discograms and saying that he was unaware of a cervical discogram causing an injury. PX 15 p.31-33

Dr. Wayne testified that Dr. Rutz's opinion on how to treat a disc injury where there was not evidence of radiculopathy was not unreasonable, he just disagreed with that opinion. He said there was nothing inherently unreasonable about either of their positions, and that it was common for doctors to disagree. He also agreed that conservative treatment had not thus far caused Petitioner's condition to improve. RX 2 p.51,52,55

The Arbitrator finds that Petitioner's current condition of ill-being, discogenic neck pain, cervical disc herniation and cervical annular tearing of the C4/5 and C5/6 discs, is causally related to the accident of October 30, 2018. The Arbitrator further finds that the recommended treatment of C4/5 and C5/6 arthroplasty is reasonable and is necessitated by the accident of October 30, 2018. These findings are based upon both the chain of events and Dr. Rutz's opinions, which the Arbitrator accepts, while also rejecting the opinions of Dr. Wayne. Dr. Rutz has performed over 600 surgeries of this type, while Dr. Wayne is not a surgeon, and his opinions in this regard hold lesser weight. Further, Dr. Wayne's recommendation of further conservative care following numerous months of conservative care without improvement would not seem to be productive.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC008352
Case Name	GARCIA, INOCENCIO v. PRESENCE SAINT JOSEPH HOSPITAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0424
Number of Pages of Decision	34
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Jonathan Schlack
Respondent Attorney	Lisa Azoory

DATE FILED: 8/23/2021

/s/Kathryn Doerries, 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARCIA, INOCENCIO,

Petitioner,

vs. NO: 17 WC 008352

PRESENCE SAINT JOSEPH HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Arbitrator's decision in its entirety except the Commission views the evidence regarding the issue of notice differently than the Arbitrator. The Arbitrator's decision held that Petitioner did not provide timely notice of his accident to Respondent, however, the Commission does not agree for the following reasons.

The Arbitrator's findings and conclusions of law regarding notice relied upon the fact that there was no evidence offered that Petitioner's alleged injuries occurred or manifested on April 1st, 2015. There was no evidence in the record agreeing with that claim date, even after Petitioner testified at trial and failed to offer testimony to support an April 1, 2015 accident date. Petitioner introduced his time logs contemporaneous with the alleged manifestation date. RX7. Based on the time logs, Petitioner worked before and after the manifestation date, up until at least August 21, 2015. According to the logs, Petitioner did not work on April 1, 2015 or April 2, 2015 - the logs note unpaid time off on those days and Petitioner resumed work thereafter with no interruption. The Arbitrator found it significant that Petitioner- albeit in a very confused manner- offered no testimony that he specifically notified his employer about any injury. The Arbitrator noted that the

co-worker named "Mary" who allegedly ignored Petitioner's complaints was not present at trial and she did not appear to exist according to Respondent's credible witness Miguel Valdes. It is unknown what position Mary held and when she was allegedly notified about Petitioner's injuries, if at all, and what role she allegedly played in the injury reporting process. In connection with notice, the Arbitrator found that it was significant the records reflect Petitioner went directly into Employee Health in May 2015, December 2015, and in March, 2016, with no recitation whatsoever of a workplace injury within the notes from the Employee Health, notes which were written by Respondent's credible witness Dawn Pallela, and written at the time of the visits. (RX6) In light of the foregoing, the Arbitrator found and concluded that Petitioner failed to give timely notice of his alleged injuries of April 1, 2015, to Respondent pursuant to §6(c) of the Act. *820 ILCS 305/6.*

However, the parties stipulated that if the medical bills were awarded, Respondent will pay providers directly per the medical fee schedule and Respondent will get §8(j) credit for bills paid under the Respondent's group policy and, further, that Respondent will hold Petitioner harmless for those bills paid under group. (RX5)

§8(j) of the Worker's Compensation Act ("Act") states, in pertinent part,

> In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments. *820 ILCS 305/8*.

Petitioner's medical benefits were paid by Respondent's group health provider until July 16, 2017. (PX7, 1, 2) As such, the 45-day period which injured workers are required to report their accident, would not have run until August 30, 2017.

Petitioner's Application for Adjustment of Claim was filed on March 20, 2017. (AX2) Dawn Pallela was called as a witness by Respondent and testified that she was the Employee Health Nurse at the time of the alleged accident. As part of Pallela's job duties, she testified that she facilitates ADA requests and requirements of Workers' Compensation case management, and facilitates return-to-work clearances. Pallela also testified that she assesses the injured worker when they come in and triages them for medical evaluation, and treatment and coordinates their care moving forward. (T, 93-94) Pallela further testified that in April 2015, 1,400 employees were under her charge. If one of those were injured, she would know about it. She worked in the same location as Petitioner. Pallela met with Petitioner five times between May 2015 and March 2016 in Employee Health. At no time did Petitioner mention a workplace injury. (T, 101-102) Finally, Pallela testified that the first notice she received that Petitioner was alleging he sustained

a worker's compensation injury was when she spoke with Petitioner's attorney's office on April 27, 2017, regarding setting up a claim. (T, 103-104)

Therefore, the Commission finds that Petitioner provided timely notice of the alleged accident pursuant to the provisions of §8(j) of the Act, wherein the 45-day notice window after the last payment of medical by Respondent's group provider ended on August 30, 2017, and Pallela, the Respondent's Employee Health Nurse, acknowledged that she was told of the Worker's Compensation claim months before that date, on April 27, 2017.

The Commission affirms and adopts all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on July 29, 2019, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on April 1, 2015, and that Petitioner failed to prove that his conditions of ill- being are related to the alleged work injuries. Therefore, his claim for compensation is denied.

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 23, 2021

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

KAD/bsd
O062221

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0424
NOTICE OF ARBITRATOR DECISION

GARCIA, INOCENCIO Case# **17WC008352**

Employee/Petitioner

PRESENCE ST JOSEPH HOSPITAL

Employer/Respondent

On 7/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4069 LAW OFFICE OF JONATHAN SCHLACK
200 N LASALLE ST
SUITE 2830
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
LISA AZOORY-KELLER
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

Inocencio Garcia,
Employee/Petitioner

v.

Presence Saint Joseph Hospital,
Employer/Respondent

Case # **17** WC **8352**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **June 26, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 1, 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 not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**22, 880.00**; the average weekly wage was $**440.00**.

On the date of accident, Petitioner was **66** 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 $**0** under Section 8(j) of the Act.

ORDER

The Arbitrator finds and concludes Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on April 1, 2015, and that Petitioner's conditions of ill-being are not related to the alleged work injuries. Therefore, his claim for compensation is denied.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

July 26, 2019
Date

JUL 29 2019

MEMORANDUM OF DECISION OF ARBITRATOR
STATEMENT OF FACTS

Petitioner, Inocencio Garcia, was employed by Presence Saint Joseph Hospital as a Housekeeper (also known as Environmental Service Worker, or "EVS worker") on the alleged manifestation date of April 1, 2015. On his Application for Adjustment of Claim, Petitioner alleged injury to multiple body parts as a result of the April 1, 2015 injury. (AX2)

For some amount of time (not unidentified or clarified in the record) Petitioner worked as a Housekeeper in the surgical suites but stated that he held other positions at Presence throughout his 15 years at the Hospital. Petitioner stated that he worked "here and there" prior to working in Housekeeping. (T. 17)

Petitioner testified that his job duties included using a solution ("like water") as part of his job (T. 18), and preparing beds for patients. Petitioner stated that he was required to place sheets on beds (T. 19), clean the sheets from the patient's bed (T. 20), clean the floors, (T. 20) and "take everything else out." (T. 20). In addition to preparing beds, Petitioner testified that he was required to put little towels on the bed (T. 21), and change little carts, which contained containers of blood. (T. 21). After further questioning, Petitioner also stated that he had to place chairs in a storeroom as part of his job. (T. 29). Specifically, Petitioner testified that the chair was on top of the surgical table, and that he would place it on a cart that was on the floor. (T. 31).

Petitioner testified that he would be asked to work harder when people would get laid off (T. 34) and that he refused to work harder because he would get tired. (Id). Petitioner stated that "The man that wanted to make me work" retired. (T. 34-35).

Petitioner's attorney asked Petitioner whether his co-worker went on vacation in early 2015. Petitioner testified that "My co-worker did not go on vacation. He died." (T. 36). Petitioner then stated that he did not remember working in the first three months of 2015. (T. 37).

Petitioner stated on direct examination that he did not mention to anyone at the hospital that he was experiencing pain, but that "Mary" would ignore his complaints. (T. 43-45).

In the course of an eight-hour shift, Petitioner testified that he would need to lift a big chair approximately two to three times. (T. 49) Petitioner then stated that he would need to move a "Jackson table" approximately 60 feet, but did not specify the number of times throughout his shift

the table would need to be moved. (T. 51). Petitioner then stated that he would need to move bags of laundry as part of his job, (T. 51-52), and put the laundry into a linen chute off the ground. (T. 54).

On cross-examination, Petitioner testified that he filled out a patient questionnaire for Presence Saint Joseph Hospital on April 22, 2015. (T. 58-59) Regarding when his problem began, Petitioner admitted that he indicated "six months ago". (T. 59). Regarding the etiology of his pain, Petitioner admitted that he wrote "no known reason." (T. 59). When asked on cross-examination how he could fill out the questionnaire if he didn't know English, Petitioner testified that he did not write the questionnaire, but only signed it. (T. 60).

Petitioner agreed that he had a cervical injection with Dr. Brown at Presence Saint Joseph Hospital in July, 2015, and that he never mentioned to Dr. Brown that he got hurt at work. (T. 61). When asked whether he told Dr. Lichtenbaum about work duties, Petitioner testified that "he knew" (T. 62). He stated that he advised Dr. Lichtenbaum about working with Jackson tables and laundry bags. (T. 62-63).

Petitioner testified on cross-examination that he saw many physicians at the University of Illinois. If none of the records from University of Illinois indicated that he got hurt at work, Petitioner testified that "possibly," all of the notes were wrong. (T. 65). Petitioner further testified that he advised Dr. Goldberg that he got hurt at work, and that if Dr. Goldberg's notes did not mention anything about work, Dr. Goldberg must have gotten his notes wrong. (T. 65-66).

Petitioner filed his Application for Adjustment of Claim with the Illinois Workers' Compensation Commission on March 20, 2017. (AX2) He came under the care of Dr. Preston Wolin one week later, on March 28, 2017. Petitioner testified that he told Dr. Wolin "all my case." (T. 67). When asked whether he advised Dr. Wolin of his job duties, Petitioner stated that "I told him what I would move around over there." (T. 68)

Petitioner testified he visited Employee Health approximately two to three times in calendar years 2015 and 2016. (T. 69) If the records from Employee Health were silent regarding a work injury or job duties, Petitioner testified that Employee Health got their notes wrong. (T. 70). On re-direct examination, Petitioner's attorney asked Petitioner the following question, "So if those doctors don't put something in the medical records that they should, that's not really your problem, is it; it's theirs?" The Petitioner answered "Of course, no." (T. 77). Petitioner testified on re-cross examination

that he was sometimes accompanied by an interpreter at his office visits, and sometimes accompanied by his son to his medical visits. (T. 78).

Regarding his Diabetes, Petitioner testified on cross-examination that he never refused to take insulin, and that his Diabetes was always well-controlled. (T. 69).

Testimony of Miguel Valdes

Miguel Valdes testified on behalf of Respondent. Valdes stated that at the time of the alleged injury/manifestation date, he worked for Presence Saint Joseph Hospital (T. 81), and that currently (at the time of trial) he was employed with Advocate Aurora Christ Hospital. (T. 80). Valdes stated that he was testifying pursuant to subpoena at trial, that he needed to show the subpoena to his current employer to take the day off, and that his appearance at trial was difficult due to the fact that he had recently started a new job. (T. 81). At the time of the alleged injury, Valdes worked as Operations Manager of Housekeeping at Presence Saint Joseph Hospital. Valdes was Petitioner's direct supervisor, and Petitioner had no other supervisors at the time of the alleged injury. (T. 82). Valdes was in contact with Petitioner approximately once per day. (T. 82). If Petitioner sustained an injury at work, Valdes testified he (Valdes) would have been the individual to be notified. (T. 83).

Valdes testified Petitioner never, at any time throughout his employ with Presence, reported an injury to him. (T. 83). If an injury had been reported, Valdes would have filled out injury forms in his office regarding the location, type of injury, date of injury and employee's name. (T. 83). Valdes testified he would always document an injury in writing to protect the employee, himself, and the company. (T. 83-84). Valdes testified he was no longer in communication with anyone from Presence, had not spoken with anyone from Presence regarding the case, (T. 84), and his current employer is in no way affiliated with Presence Saint Joseph Hospital and/or AMITA. (T. 88-89)

Valdes testified he was familiar with the job duties of a Housekeeper/EVS worker at Presence Saint Joseph Hospital. Valdes testified Housekeepers/EVS workers were responsible for cleaning operating rooms, mopping the floors, pulling the soiled linens, wiping down tables and medical equipment, and putting linens on the beds. (T. 83). Valdes testified Petitioner's job was primarily a cleaning job. (T. 84). Valdes testified the job description (Respondent's Deposition Exhibit 4) was an accurate recitation of the job duties of an EVS worker. Valdes testified the EVS worker was not

required to handle medical equipment and individuals in the Nursing department (who were trained to handle medical equipment properly), were responsible for moving medical equipment. (T. 86).

With regard to the "Jackson table," Valdes testified the EVS worker would possibly be required to move the Jackson table a few feet to the left or to the right, in order to properly mop the room, and that the Jackson table was on wheels. (T. 87). Valdes testified he did not know an individual named "Mary," and that he knew all of the employees who had direction over Petitioner's job at the time he (Valdes) was employed with Presence. (T. 87-88).

Testimony of Dawn Palella

Dawn Palella testified on behalf of Respondent. Palella testified her job title is Employee Health Nurse and she has been employed with Presence Saint Joseph Hospital for approximately eight years. (T. 94). As part of her job as Employee Health Nurse, Palella testified she assesses injured workers, triages them to any sort of medical evaluation, and coordinates care moving forward. (T. 94). Palella worked at the same location as Petitioner in April 2015. (T. 95). Regarding the injury reporting process, Palella testified an injured worker would either report injury to the manager or come directly to Employee Health. Thereafter, an injured employee would need to complete necessary paperwork. (T. 95). Palella identified Miguel Valdes as Petitioner's manager at the time of the alleged accident and testified she did not speak with Valdes (aside from pleasantries) prior to trial. (T. 96).

Palella testified that if a manager is notified of a workplace injury, the manager either initiates the injury paperwork, or send the employee to Employee Health. (T. 96). If an employee sustains an injury that is reported, they are asked to personally fill out an incident report. (T. 98). Additionally, an employee is also required to sign a HIPAA release, fill out a preferred provider worksheet, and fill out an incident report. (T. 98).

Palella testified Petitioner never reported a workplace incident in calendar year 2015 or calendar year 2016. The first time Palella was notified of an alleged injury was in April 2017, when she was contacted by Petitioner's attorney's office. (T. 103). This fact was unrebutted at trial.

Palella testified that on May 29, 2015, Petitioner came directly to Employee Health to get his TB test. (T. 99). Petitioner returned to get his TB test read approximately two days later. (T. 100). Petitioner then came to Employee Health for a flu vaccination in December 2015. (T. 100). The next time Palella personally saw Petitioner was on March 21, 2016, for his annual TB testing and mask fitting. (T. 101). In total, Palella testified she met with Petitioner personally five times between May, 2015 and March, 2016 inside Employee Health, and Petitioner never mentioned a workplace injury. (T. 102). Palella testified Petitioner would have had an opportunity to report a workplace injury at all of those times. (T. 102). Respondent's Exhibit 6 includes notes from Employee Health, handwritten by Palella at the time of Petitioner's encounters in 2015 and 2016. (RX 6)

Palella testified that when a workplace injury is reported, her objective is to take care of the employee, and generally help the employee get the care that they need. (T. 102). Palella testified Miguel Valdes never sent Petitioner to Employee Health for a reported injury at any time throughout Petitioner's employ with Presence. (T. 104).

Like Valdes, Palella testified she was familiar with the job duties of a Housekeeper/Environmental Service Worker at Presence Saint Joseph Hospital. (T. 104). Palella testified EVS workers are responsible for sanitizing, cleaning, disinfecting the areas of the hospital, dusting and mopping. (T. 105). Palella testified the job was primarily a cleaning job. (T. 105).

Palella testified she had been inside of an operating room at Presence Saint Joseph Hospital, most recently in May, 2019. (T. 105). Palella testified she was familiar with a "beach chair positioner," but that the picture identified as Petitioner's Exhibit 8 was not a picture which was taken inside the OR of Presence Saint Joseph Hospital. (T. 106). Palella testifiedt EVS workers were not required to handle medical equipment, and that the surgical team, physician, and surgical techs would be responsible for moving that equipment. (T. 107). The Housekeeper (EVS worker) would need to wipe down and clean the medical equipment, but not move it. (T. 107).

Petitioner's Medical Chronology

The medical records entered into evidence pre-date the alleged date of injury/manifestation date. In December 2013, Petitioner underwent a cervical spine MRI, referenced by Dr. Wolin in his March 28, 2017 report. (PX 4, p. 7). Dr. Wolin stated that the cervical spine MRI from 2013

demonstrated multilevel degenerative changes in the cervical spine, with associated myelomalacic changes in the cervical cord.

In February 2014, Petitioner was seen at Presence Saint Joseph Hospital for neck pain. (RX 2, p. 4-5). On March 11, 2014, Petitioner was again seen at Presence Saint Joseph Hospital for neck pain and hand pain (RX 2, p. 27). On April 2, 2014, Petitioner was seen by Occupational Therapy with "pain and paresthesias consistent with median nerve entrapment/neuropathy of bilateral distal upper extremities." (RX 2, p. 76).

On April 11, 2014, an EMG was performed at Presence Saint Joseph Hospital, due to Petitioner complaining of pain in both his upper limbs. (RX 2, p. 114). Dr. Lee wrote that the provisional diagnosis was "pain in both upper limbs, cause undetermined." (Id.)

The first medical note **post-dating** the alleged accident is April 22, 2015 from Presence Saint Joseph Hospital. On that date, Petitioner's therapist wrote, "Pain was initially just in wrists and hands, but now he complains of pain in the neck and forearms (right greater than left)." The note indicates that Petitioner was "unsure of cause of pain" and "unsure of exact date." (RX2, p. A 210) Petitioner's therapist stated that Petitioner presented with symptoms consistent with cervical radiculopathy and had functional limitations throughout his cervical paraspinal and bilateral upper traps. There is no mention of work. (RX 2, pp. A 210- A 213).

In a patient questionnaire dated April 22, 2015, Petitioner stated that his arm and neck pain began six months ago with "no known reason." (RX 2, p. 223). This pre-dates the alleged April 1, 2015 date of accident. The therapist noted a past medical history of Diabetes. There is no mention of work.

On April 29, 2015, Petitioner had an initial occupational therapy evaluation for his bilateral hand pain and forearm pain at Presence Saint Joseph Hospital. **Petitioner listed his onset of pain as "last year."** (PX 1, p. 32). The note specifically states that, "He reports performance in his job duties does not have an impact on his symptoms." (PX 1, p. 32).

On May 5, 2015, Petitioner had physical therapy for his cervical spine and occupational therapy for his bilateral upper extremities at Presence Saint Joseph Hospital. Petitioner expressed his frustration that physical therapy and occupational therapy were not helping him. There is no mention of work. (PX 1, pp. 42-43).

On July 13, 2015, Petitioner underwent a cervical epidural steroid injection with Dr. Brown at Presence Saint Joseph Hospital. The indication for the procedure was "neck pain and right upper extremity radiculopathy." There is no mention of work.

On August 14, 2015, Petitioner presented to Dr. Lichtenbaum at Presence Saint Joseph Hospital for an initial evaluation. Dr. Lichtenbaum wrote that Petitioner presented with neck pain radiating into his bilateral extremities and hands with no preceding event. (PX 2, p. 4). There is no mention of work.

On August 25, 2015, Petitioner underwent an MRI of the cervical spine. The interpreting radiologist made the following impressions: (1) C4-C5 disc osteophyte and ligamentum flavum hypertrophy resulting in severe spinal canal stenosis impinging the cervical spinal cord, with suggestion of myomalacia at this level and (2) Severe C4-C4 spinal canal stenosis, secondary to disc osteophyte impinging the cervical spine cord without evidence of abnormal cord signal. (PX 1, p. 124).

On September 28, 2015, Petitioner underwent cervical surgery with Dr. Lichtenbaum at Presence Saint Joseph Hospital. The hospital course indicates that Petitioner started having right arm pain in 2013. (PX 1, p. 140). Petitioner underwent a C3-4 and C4-5 ACDF, with no complications, and was discharged on October 1, 2015. A separate note from the hospital admission indicates that Petitioner had a history of cervical neck pain with bilateral upper extremity radiation for "over a year."

On **February 12, 2016**, Petitioner was evaluated by Dr. Gramelspacher at the University of Illinois for a new patient consult. Dr. Gramelspacher indicated the Petitioner was having right shoulder pain with **"no injuries to the shoulder."** (RX 3, p. 167). Petitioner told Dr. Gramelspacher that he wanted to get his Diabetes under control and thought that it was out of control. (Id). Petitioner reported that his physicians were telling him that he needed to be on insulin, but that he did not want to take medication. The Petitioner reported to Dr. Gramelspacher that he just needed to understand what to eat and what not to eat. **There is no mention of work or a work injury.**

On February 25, 2016, Petitioner was evaluated by Dr. Borkowsky. The note indicates, "He thinks that all doctors want to do is push insulin but that he doesn't need it." Petitioner complained of right shoulder pain, with no mention of work. The physician spent 30 minutes with the Petitioner

explaining the potential complications of uncontrolled Diabetes, and the need for insulin. (RX 3, p. 163).

On March 2, 2016, Petitioner was seen for management of his Type 2 Diabetes at the University of Illinois. Petitioner was to continue lifestyle modifications and continue blood glucose testing as ordered. (RX 3, p. 150).

On March 17, 2016, Petitioner had a follow-up visit with Dr. Borkowsky. The note indicates that Petitioner did not check his glucose and did not have test strips. Petitioner believed that his machine expired and was over one year old. The note further indicates that Petitioner's A1C levels were 12 in February 2016, and that he was refusing insulin. (RX 3, p. 160). There is no mention of work.

On March 18, 2016, Petitioner was evaluated by Dr. Rotman at the University of Illinois. Dr. Rotman wrote that Petitioner presented with right shoulder pain and neck pain, with associated numbness and tingling in the first three digits of his hand bilaterally, **"present for many years."** (RX 3, p. 208). The only notation of work is that "Petitioner works as a Housekeeper and is still able to work in spite of shoulder pain." (RX 3, p. 208). Dr. Rotman ordered X-rays of the neck, an EMG of the bilateral upper extremities and an MRI of the right shoulder.

On May 23, 2016, Petitioner was evaluated by Gramelspacher at the University of Illinois. Petitioner reported to the physician that his right shoulder was hurting and was prescribed Norco on that date. The note indicates that the physician encouraged Petitioner to take ASA 81 milligrams daily, but "he did not want to." Dr. Gramelspacher further stated that Petitioner was very reluctant to take insulin. (RX 3, pp. 156-157). There is no mention of work.

On June 20, 2016, Petitioner returned to Dr. Gramelspacher, stating that his primary concern was right shoulder/arm pain. The note indicates "He is annoyed with me about asking about his Diabetes. He says he does not have time in the morning to check his blood sugar in the morning because he goes to work early. In the afternoon, his blood sugar is 90s to 100s." (RX 3, p. 154).

On July 11, 2016, Petitioner was evaluated by orthopedic physician Dr. Benjamin Goldberg in the orthopedic department of the University of Illinois for right shoulder pain. Dr. Goldberg indicated that Petitioner had right shoulder pain and stiffness "that had been going on since about May of 2015." Dr. Goldberg then indicated that Petitioner had a one-year history of right shoulder

pain and stiffness, which was not improved with conservative measures. Petitioner reported to Dr. Goldberg that the cervical surgery helped him somewhat with the shoulder pain, but that the shoulder pain had returned and stiffness had worsened. There is no mention of work, or a work injury. (RX 3, p 203-205). Dr. Goldberg specifically noted that Petitioner's Diabetes was poorly controlled, and that it was "likely that his adhesive capsulitis is also due to his poor diabetic control." Dr. Goldberg recommended a right arthroscopic capsular release and distal clavicle excision and tenodesis. (Id.)

On December 19, 2016, Petitioner underwent right shoulder surgery. The procedure was a right shoulder manipulation under anesthesia, capsular release, biceps tenodesis and Mumford procedure. Dr. Goldberg performed the procedure at the University of Illinois. The pre and post-operative diagnoses were the same, that of right shoulder adhesive capsulitis, biceps tendinopathy, and AC joint arthritis. (RX 3, p. 174).

On December 23, 2016, Petitioner had his first post-operative visit with Dr. Goldberg. The physician stated that Petitioner was doing well. Physical examination of the right shoulder was very guarded with range of motion testing. Dr. Goldberg stated that Petitioner was able to stretch Petitioner out to approximately 90-100 degrees of forward flexion, but that Petitioner was very guarded. Dr. Goldberg recommended physical therapy. There is no mention of work. (RX 3, p. 191).

On January 20, 2017, Petitioner had a follow-up visit with Dr. Goldberg, reporting continued stiffness. Goldberg noted that Petitioner had been doing physical therapy at home two to three times per week, but still had significant pain. Dr. Goldberg again noted that Petitioner was very guarded on physical examination and did not want to move his shoulder upward. Petitioner displayed limited internal and external rotation to about ten degrees of internal extension, 30 degrees of external rotation, and 90 degrees of abduction. Dr. Goldberg refilled Petitioner's prescription for Norco and recommended continued therapy. (RX 3, pp. 189-190).

On February 17, 2017, Petitioner returned to Dr. Goldberg, reporting continued stiffness. Petitioner was mostly doing physical therapy at home, but still reported significant pain post-surgically. Dr. Goldberg noted that Petitioner was also complaining of dorsal wrist pain, as well as pain in the right thumb, for which Dr. Goldberg recommended X-rays. The physician also ordered

an MRI of the cervical spine, as well as an EMG of the right upper extremity to rule out neuropathy and radiculopathy. (RX 3, pp. 187-188).

On March 20, 2017, Petitioner filed his Application for Adjustment of Claim with the Illinois Workers' Compensation Commission. (AX 2).

One week later, on March 28, 2017, Petitioner came under the care of Dr. Preston Wolin at the Center for Athletic Medicine. Petitioner was accompanied by an interpreter to the appointment, identified as his son. Regarding the history of injury, Dr. Wolin wrote that "The patient states that in April of 2015 he had to cover for a co-worker who took a vacation. He states that he had to do a lot of extra work at this time which caused his pain in his neck and down his right arm to his wrist and fingers." (PX 4, p. 3). There are no job duties listed, and Wolin noted that the Petitioner had Diabetes and Hypertension. Dr. Wolin's assessment was pain in the right shoulder, and adhesive capsulitis of the right shoulder. Dr. Wolin recommended an MRI arthrogram of the right shoulder and recommended that Petitioner stay off work. Dr. Wolin noted at the first office visit that he did not have any medical records to review and noted that he would be "obtaining the old records." (PX 4, p. 7).

On May 12, 2017, Petitioner returned to Dr. Goldberg at the University of Illinois. Petitioner told Dr. Goldberg that he was being seen by another physician, but still wanted Dr. Goldberg to fill out disability paperwork for him. However, Dr. Goldberg noted that Petitioner missed his last appointment and did not feel comfortable filling out such paperwork. (RX 3, pp. 183-184).

On September 1, 2017, Petitioner returned to Dr. Wolin, who noted that Petitioner had not yet undergone the MRI arthrogram. Petitioner reported pain in his right shoulder, pain in the neck and numbness and tingling in both of his upper extremities, especially all of the fingers in his right hand. Dr. Wolin made an assessment of pain in the right shoulder and administered a steroid injection into the right shoulder intraarticular joint. There is no mention of work. Dr. Wolin's note on this date is silent on retrieving the "old records" referenced in the previous note. Dr. Wolin noted the importance of Petitioner keeping his Diabetes under control and believed that hemoglobin A1C would be helpful. (PX 4, p. 12).

On October 10, 2017, Petitioner was seen in follow up by Dr. Wolin, reporting the same symptoms. Dr. Wolin stated that he reviewed an MRI arthrogram dated October 2. According to Dr.

Wolin's reading, there was no significant partial-thickness or full-thickness rotator cuff tearing, and the changes were consistent with biceps tenodesis. Dr. Wolin stated that Petitioner's diagnosis was recurrent adhesive capsulitis. Dr. Wolin wrote that there was some overlap between Petitioner's condition in his neck and shoulder and believed that the primary pathology at the present time was the shoulder. Petitioner stated his desire to proceed with surgery. Dr. Wolin explained a capsular release may achieve a less than optimal result. There is no mention of work. (PX 4, pp. 15-16).

On January 30, 2018, Petitioner was seen in follow up by Dr. Wolin. Petitioner reported increased pain in his right shoulder with numbness and tingling in all of the fingers of both hands. Dr. Wolin wrote that "of note is the fact that this existed prior to the cervical and shoulder surgeries." Dr. Wolin stated that Petitioner would benefit from an arthroscopic periscapular release and recommended an EMG. Dr. Wolin recommended that the EMG be done by Dr. Nicola at the University of Illinois. There is no mention of work, aside from Dr. Wolin stating that Petitioner should remain off work. (PX 4, pp. 17-19).

On November 1, 2018, Petitioner underwent a Section 12 examination ("IME") at Respondent's request with Dr. James Cohen at Illinois Bone & Joint Institute. (Resp. Dep. Ex.2) Petitioner was accompanied to the IME by a professional interpreter. Dr. Cohen reviewed extensive medical records, beginning in December 2013, and all the way up to January 30, 2018, and also reviewed a job description of Environmental Service Worker at Presence Saint Joseph Hospital.

At the IME, physical examination demonstrated very limited cervical range of motion in all directions. Spurling's testing to the right produced pain at the base of the neck, trapezial area, and increased symptoms down the arm and forearm.

Dr. Cohen did not believe that Petitioner's conditions of ill-being were related to any alleged April, 2015 injury or repetitive trauma. **Dr. Cohen noted there was no recitation of any work activities or acute traumatic episode within the voluminous medical records.** Dr. Cohen noted Petitioner's pre-existing condition in his cervical spine and bilateral upper extremities, pre-dating the alleged injury by years. Dr. Cohen discussed a very detailed history of poorly managed Diabetes within the medical records, with poor compliance with doctors' recommendations. (Resp. Dep. Exhibit 2) As Dr. Cohen noted, the poorly-controlled Diabetes was acutely relevant to Petitioner's diagnosis of adhesive capsulitis, an issue which Dr. Wolin appeared to deny.

On December 18, 2018, Dr. Cohen authored an IME addendum. (Resp. Deposition Ex. 3) In the addendum, Dr. Cohen reviewed an MRI arthrogram from October 2, 2017. Dr. Cohen's opinions were unchanged after personally reviewing the diagnostic films.

Conclusions of Law

In support of the Arbitrator's Decision with respect to disputed issues (C) Accident and (F) Causal Connection, the Arbitrator makes the following findings and conclusions:

The Arbitrator incorporates herein all of the facts found in the Statement of Facts section above.

Based on a thorough review of the entire record, including - and especially - the Transcript of Evidence on Arbitration - the Arbitrator finds and concludes Petitioner has failed to prove by a preponderance of the credible evidence he sustained accidental injuries arising out of and in the course of his employment with Respondent **on April 1, 2015** and Petitioner has failed to prove a causal connection exists between those injuries allegedly sustained on April 1, 2015 and his current condition of ill-being. Petitioner's claim for compensation is therefore denied.

The Arbitrator further finds and concludes the preponderance of the evidence indicates Petitioner is not credible. The Arbitrator emphasizes that a Spanish translator was retained and was used to translate for Petitioner at trial. However, even the use of a qualified translator did not remove the obvious and serious difficulties and obstacles presented in Petitioner's testimony, which was contradictory, confusing, and at times incoherent. On multiple occasions on the record, the Arbitrator admonished Petitioner to answer only the questions asked of him, but to no avail. The Arbitrator had to intervene and ask his own questions in an attempt to elicit some clarity and understanding. The ultimate result of this testimony was that Petitioner was unable to meet the necessary burden of proof in his claim.

Further, and also very significant, the Arbitrator further emphasizes that this claim was presented and argued as a **"repetitive trauma" claim**. In such a claim, there are legal burdens of proof that **must** be met; Petitioner has failed to meet these required burdens. An employee who

alleges injury from repetitive trauma must still meet the same standard of proof as other claimants alleging accidental injury. *Three "D" Discount Store v. Industrial Comm'n, 198 Ill. App. 3d 43, 47, 556 N.E.2d 261, 264, 144 Ill. Dec. 794 (1989).* The employee must show that the injury is work related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Com., 115 Ill. 2d 524, 505 N.E.2d 1026, 1987 Ill. LEXIS 161, 106 111.* Dec. 235 (Ill. 1987). An injury is considered "accidental" even though it develops gradually over a period of time as a result of repetitive trauma, without requiring complete dysfunction, if it is caused by the performance of claimant's job. *Peoria County Belwood Nursing Home v. Industrial Comm'n (1987), 115 Ill. 2d 524, 529-30, 505 N.E.2d 1026, 1028, 106 Ill. Dec. 235.*

An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act but must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006).* **That is, specifically, "The employee must allege and prove a single, definable accident" that "manifests itself" on a specific date**. *White v. Workers' Compensation Comm'n*, 374 Ill. App.3d 907, 910, 873 N.E. 2d 388, 391 (2007). "The phrase "manifests itself' signifies "the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person."

The standard for determining the "**manifestation date"** in a repetitive trauma case is flexible and fact-specific and is guided by considerations of fairness. *Durand*, 224 Ill. 2d at 69, 71 ("The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer's insurance carrier."); see also *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 612, 531 N.E.2d 174, 126 Ill. Dec. 41 (1988); *Three "D" Discount Store v. Industrial Comm'n*, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261, 144 Ill. Dec. 794 (1989). The date on which the employee notices a repetitive trauma injury is not necessarily the manifestation date. *Oscar Mayer & Co.*, 176 Ill. App. 3d at 611; see also *Durand*, 224 Ill. 2d at 68. Instead, the date on [**22] which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date. *Oscar Mayer & Co.*, 176 Ill. App. 3d at 611; see also *Durand,* 224 Ill. 2d at 68-69. "[C]ourts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer

perform work activities." *Durand*, 224 Ill. 2d at 72. A formal diagnosis is not required. Id. However, because repetitive trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. Id.; see also *Oscar Mayer & Co.*, 176 Ill. App. 3d at 610.

As such, in this "repetitive trauma" claim, Petitioner must allege and then prove a **"manifestation date."**

Under the facts unique to this case, the Arbitrator finds and concludes Petitioner has failed to meet his burden of proof and has failed to prove that April 1, 2015 is the "manifestation date." **The Arbitrator places great emphasis on the fact that at trial Petitioner offered not one word of testimony suggesting – let alone indicating or proving - that April 1, 2015 is the "manifestation date." The date "April 1, 2015" was not mentioned even once in all the trial testimony. Further, there is no record of any kind in evidence that indicates – or even suggests – that "April 1, 2015" is – or should or could be - the appropriate "manifestation date." There is nothing at all in the record to support the assertion that "April 1, 2015" is the - or a – proper "manifestation date." (Incidentally, no other date was proferred as an alternative "manifestation date.")**

Petitioner's failure to offer any evidence proving that April 1, 2015 is the "manifestation date" as alleged is fatal to his claim.

Further, the clear weight of the credible evidence in the record does **not** support a finding of **any** compensable accident. A Decision by the Commission cannot be based on speculation or conjecture. *Deere & Company v. Industrial Commission*, 47 Ill.2d 144 (1970). In the instant case, ***all*** of the records post-dating the alleged manifestation date -- for a full two years -- **identify no trauma, and do not reference work whatsoever.** Even after two years (when Petitioner saw Dr. Wolin for the first time), **Petitioner's work duties are never referenced**, and Dr. Wolin simply references the fact that Petitioner "did a lot of heavy lifting" in April of 2015. The first mention of alleged work duties are only discussed in Dr. Wolin's deposition (and discussed by Dr. Wolin, not the Petitioner), 3-1/2 years after the alleged manifestation date. **The record further indicates that the first time Petitioner**

mentioned his specific work duties was during his trial testimony, more than four years after the alleged manifestation date.

Petitioner asserts repetitive trauma, yet *never, at any point during trial,* testified that his job duties were a cause of his conditions. There is also conflicting evidence as to whether Petitioner actually ever told any his providers that his specific job duties contributed to his conditions. Petitioner was seen by a long list of physicians, therapists, nurses and other health care providers after the "manifestation date" but, **according to the actual medical records, he failed to mention his work duties**. Petitioner, not credibly, **sometimes** in his trial testimony denied this reality (e.g., T. 57, but Petitioner then contradicted himself moments later when he inexplicably denied the therapists got their notes wrong, T. 57-58). At other times, Petitioner did not dispute that the treating records which were absent any mention of work were accurate. (e.g., T. 61, 63-65) In this regard, Petitioner clearly was not credible. Accordingly, the Arbitrator places far greater weight, reliance and credibility on what the actual records reveal.

To the contrary, and very significantly, Petitioner told his physical therapist on April 29, 2015 that the performance of his job duties **did not** have any impact on his symptoms. (PX1, p. 32) Petitioner advised Dr. Rotman on March 18, 2016 that he was **still able to work** in spite of his shoulder pain. (RX 3, p. 208). Petitioner also testified that he refused to work harder when asked, because he would get tired. (T. 34) Based on the foregoing, it would appear that Petitioner's job duties as described (primarily cleaning, wiping, and placing sheets on beds) were so light that his symptoms were not affected by working. If Petitioner *was* asked to "work harder", he admittedly refused to do so.

Petitioner only offered scant pieces of vague testimony about varied job duties (four years after the alleged manifestation date). In rejecting Petitioner's claim the Arbitrator notes that it entirely unknown how many months or years Petitioner worked as a Housekeeper, and what timeframe he performed the duties that he alleged he performed as part of his job. Petitioner testified that he held other job positions before he became a Housekeeper (T. 17) and couldn't even recall working in the first few months of 2015. (T. 36-37)

The evidence introduced at trial supports the fact that Petitioner's job was quite clearly a cleaning job, and that most of his tasks throughout the day were varied. By Petitioner's own

description, the job duties were light and non-strenuous. Petitioner first testified that his job involved putting sheets on beds and using a special solution to spray. When probed further, Petitioner testified that he put little towels on the beds, and little carts on the beds. After **substantial additional coaxing** on direct examination, Petitioner testified that he carried a chair two to three times per day throughout his eight-hour shift. Petitioner also stated that he moved Jackson tables, without identifying the frequency. Clearly, the cleaning tasks were Petitioner's primary responsibilities, facts which were corroborated by Respondent's two witnesses, and by the job description entered into evidence. Both Valdes and Palella testified that the Housekeeper (EVS) position was a cleaning position, and that Petitioner was required to wipe down, but not move, medical equipment.

The job description of the EVS worker (Respondent Dep. Exhibit 4) denotes a cleaning position, wherein Petitioner's job duties include cleaning patient rooms, spot washing, vacuuming and light lifting up to 15 pounds. This is consistent with testimony of both Valdes and Palella, and even the Petitioner himself, who testified primarily to the cleaning duties.

Not only did Petitioner fail to tell *any* of his physicians (including Dr. Wolin) about moving chairs and Jackson tables as part of his job, but also failed to identify the subject "Beach Chair Positioner" itself. Respondent's Exhibit 8 depicts a wide variety of Beach Chair Positioners, none of which were identified as the chair Petitioner alluded to at trial. The first time Petitioner **ever** mentioned the Beach Chair Positioner was at trial, more than four years after the alleged manifestation date. This strongly suggests to the Arbitrator that Petitioner demonstrated a self-serving motivation at trial to construct a narrative supporting compensability of his claim.

The Arbitrator relies on both certified medical records that were entered into evidence, the testimony of both Petitioner and Respondent's witnesses, and the factual information entered into evidence, which includes the following significant evidence:

- Medical records from Presence Saint Joseph Hospital (including occupational therapy records and physical therapy records) from April and May, 2015, which are utterly devoid of any mention of work, or work duties. (PX 1, RX2)

- The April 22, 2015, patient questionnaire, indicating no specific onset for Petitioner's right shoulder and cervical pain (which Petitioner initially testified that he filled out personally, but then testified that he only signed). (RX 2, p. 223)

- Medical records from Dr. Gramelspacher, which are utterly devoid of any mention of work, or work duties. (RX 3)

- Medical records from Dr. Borkowsky, which are utterly devoid of any mention of work or work duties. (RX 3)

- Medical records from Dr. Lily Rotman, which are utterly devoid of any mention of work (except that Petitioner denied injury) or work duties. (RX 3)

- Medical records from Dr Goldberg, which are utterly devoid of any mention of work or work duties. (RX 3)

- Testimony from Respondent's witness, Dawn Palella, that (1) Petitioner met with Palella personally five times in calendar years 2015 and 2016, and that Petitioner never mentioned a work-related incident, (2) that an injury was never reported and that (3) Petitioner's job was a cleaning job, requiring no moving of medical equipment, and which was consistent with the job description. (T. 98-105)

- Handwritten notes from Respondent's witness, Dawn Palella, indicating that Petitioner had been seen for TB testing, mask fitting, and annual health exams, none of which reference any work-related injury or repetitive job duties. (RX6)

- Testimony from Miguel Valdes, who stated on direct examination that he was Petitioner's only supervisor, that an injury was never reported, and that Petitioner's self-described job duties were not accurate. (T. 82-87)

- Medical records from Presence Saint Joseph Hospital pre-dating the alleged manifestation date, which demonstrate a severe cervical condition, pain in the upper limbs and median nerve entrapment/neuropathy of the bilateral distal upper extremities. (RX2)

The Arbitrator finds that Petitioner's testimony (which did not even establish any clear work duties or work injury in any event) is nowhere near sufficient to carry his burden of proof, especially in light of the longstanding principle expressed in *Shell Oil v. Industrial Commission*, 2 Ill.2d 590 (1954), where the Illinois Supreme Court held that contemporaneous medical records are more reliable than later testimony because "It is presumed that a person will not falsify such statements to a physician from whom expects and hopes to receive medical aid." **In this case, Petitioner failed to mention his work duties to all of his physicians for years, including Dr. Wolin**. The Arbitrator cannot reasonably reject the weight of ***all*** of the medical records, factual material and testimony of

Respondent's credible witnesses, and then favor Petitioner's vague, and obviously contradictory and conflicting, testimony that stands alone alone.

Among the factors to be considered in determining whether the Claimant has carried his burden his credibility. Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate credibility, evaluates a witness's demeanor internal and external consistencies in 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).

The Arbitrator finds that Petitioner was not a credible witness. Petitioner testified in an evasive manner, gave convoluted answers to questions, had a repeatedly faulty memory and testified in a self-serving way. When questioned about the lack of mention of work duties within the voluminous medical records, Petitioner testified that his physicians (perhaps all of his physicians) **got their notes wrong;** that the handwritten notes from Employee Health were wrong (T. 70); that "Mary" ignored his complaints (T. 43-45) and that "The man who made me work" retired. (T. 34-35)

In connection with credibility, the Arbitrator finds it to be particularly troubling that Petitioner testified at trial that his diabetes was well-controlled and that he always took insulin (T. 69). In contradiction to Petitioner's testimony, the medical records clearly show that Petitioner consistently refused medical advice regarding the diabetes. The medical records are replete with references to Petitioner's poorly-controlled diabetes (acutely relevant to his diagnosis of adhesive capsulitis) and include the following notations:

- On February 12, 2016, Petitioner told Dr. Gramelspacher that he wanted to get his Diabetes under control and thought that it was out of control. (RX3, p. 167).

- On February 25, 2016, Dr. Borkowsky wrote, "He thinks that all doctors want to do is push insulin, but that he doesn't need it." (RX3, p. 163). Dr. Borkowsky spent 30 minutes with the Petitioner, explaining the complications of uncontrolled Diabetes.

- On March 17, 2016, Borkowski noted that Petitioner was refusing to take Insulin. (RX3, p. 160)

- On May 23, 2016, Dr. Gramelspacher advised Petitioner to take ASA 81 milligrams daily, but that Petitioner did not want to. (RX3, pp. 156-157).

- On June 20, 2016, Petitioner was annoyed with Dr. Gramelspacher for asking about diabetes, and told the physician that he did not have time to check his blood sugar in the morning. (RX3, p. 154)

- On July 11, 2016, Dr. Goldberg wrote that Petitioner's diabetes was poorly controlled. (RX3, pp. 203-205)

The Arbitrator has considered the expert opinions of both Dr. Wolin and Dr. Cohen in this case and finds and concludes that the opinions of Dr. Wolin are entirely unpersuasive, lack weight and credibility, are contradicted by the medical records and factual material in the record, and very significantly are based on a very weak foundation – **essentially his personal general knowledge of the work duties of Petitioner's job title, but has little, if any, actual knowledge of Petitioner's actual job duties he actually performed.**

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). **The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion**. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. **If the basis of an expert's**

opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). **The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion."** Gross v. Illinois Workers' Compensation Comm'n, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. **"If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative [**18] to be reliable."** Id. "Expert opinions must be supported by facts and are only as valid as the facts underlying them." In re Joseph S., 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). **Accordingly, the Arbitrator places greater credibility, weight, and reliance on the opinions of expert examiner Dr. Cohen over the far less informed opinions of Dr. Wolin.**

Quite alarmingly, and against clear case law precedent on expert witness evidence as indicated above, Dr. Wolin premised his opinions on a long list of inferences and assumptions regarding Petitioner's job duties, based **only** on ***his*** (Dr. Wolin's) experience as a *physician* in the operating rooms of Presence Saint Joseph Hospital. **Dr. Wolin's long list of his own personal inferences and assumptions regarding Petitioner's job duties were never compared against Petitioner's actual job duties and work experience.** This is a fundamental flaw in the foundation of Dr. Wolin's opinions. **The Arbitrator finds it wholly irrelevant that Dr. Wolin witnessed other workers perform their jobs; Dr. Wolin did not observe Petitioner perform his job duties, and only knowledge is relevant in this inquiry.**

Based on the Arbitrator's review of the medical records, it appears that Dr. Wolin and his patient **never** discussed Petitioner's job duties at any time throughout the pendency of Petitioner's treatment and care. For example, Petitioner testified about dragging laundry bags (T.52-53), a job duty which Dr. Wolin never mentioned or discussed. Fundamentally, Dr. Wolin did **not** chronicle any job duties within his chart notes. Dr. Wolin did **not** review a job description. Dr. Wolin did **not** appear to

review any medical records and seemed to be under the impression (at the time of his deposition) that Petitioner's previous treating physicians had already opined on work-relatedness. Dr. Wolin denied that Petitioner's Diabetes was poorly-controlled. (PX 6)

During his deposition, Dr. Wolin was questioned on cross-examination about the fact that the records were devoid of mention of a work injury or mention of repetitive job duties. Dr. Wolin was asked the following question and provided the following answer:

Q: "Are you aware, would you be surprised then that the voluminous records show that the first time he mentioned work whatsoever was in his first office visit with you approximately two years post-accident?"

A: "I don't want to beat around the bush. I thought I read something where he told another practitioner prior to seeing me that these were work-related, that the symptoms were related to doing increased work at work. (PX 6, p. 63)."

After being confronted with the voluminous medical records on cross-examination, Dr. Wolin agreed that there was **no recitation** of any alleged work injury in the medical records from Presence Saint Joseph Hospital (PX 6, pp. 72-73), that the injury would have "probably" been freshest in Petitioner's mind after the initial onset, (PX 6, pp. 73-74) and that Petitioner did **not** tell Dr's Gramelspacher, Rotman, or Goldberg about work. (PX 6, pp. 77-80).

Dr. Wolin noted that, even though he testified on direct examination that he was familiar with the job duties of a Housekeeper - due to *his own experience as a physician* in the operating room at Presence – (PX6, p. 32) **that he did not note any job duties in his first evaluation with Petitioner**. Dr. Wolin did **not** mention a beach chair positioner, make any notation of video equipment (which Petitioner never testified about anyway), and did not mention rolling chairs (which Petitioner never testified about anyway). Dr. Wolin agreed that he did not mention mopping or sweeping and could not remember if the Petitioner discussed job duties with him. (PX 6, pp. 66-67). Further, and very significant, **Dr. Wolin admitted that he did <u>not</u> address work-relatedness in any of his chart notes.** (PX 6, pp. 68-69).

Further, even though Dr. Wolin was Petitioner's treating physician, his records make no indication that the date of accident, or the "manifestation date" was April 1, 2015, nor did he offer

any testimony in his deposition that the date of accident, or the "manifestation date" was April 1, 2015.

In contrast, the **only** medical provider or expert in this claim who discussed a claimed specific date of accident of April 1, 2015, was curiously Respondent's Section 12 examining expert Dr. James Cohen. (Respondent Dep. Exhibit 3, p. 9) However, Petitioner did not offer Dr. Cohen any evidence as to why that specific date (April 1, 2015) was chosen as the accident date. Dr. Cohen examined Petitioner on November 1, 2018. Dr. Wolin examined Petitioner first on March 28, 2017, a week after Petitioner filed his Application for Adjustment of Claim on March 20, 2017 alleging a date of accident of April 1, 2015 (Arb. Ex. No. 2). Inexplicably, Dr. Wolin was not aware of the claimed accident date of April 1, 2015. Dr. Wolin only testified, "He had injured the shoulder in April of 2015." (Petitioner Dep. Exhibit 6, p.13; 54)

Further, the Arbitrator finds and concludes Dr. Cohen's opinions to be well-reasoned, credible, and grounded in sound logic and actual knowledge of the facts of the claim – as opposed to the less than informed opinions of Dr. Wolin who had lesser knowledge of the relevant facts.. The Arbitrator notes that Dr. Cohen is a board-certified orthopedic physician, with extensive subspecialty in the upper extremities. (Respondent Dep. Exhibit 3) **The Arbitrator emphasizes Dr. Cohen was the only physician who reviewed extensive medical records, dating back to December, 2013 (that is, more extensively than Dr. Wolin's review)**. Dr. Cohen was the only physician who addressed Petitioner's pre-existing conditions and diabetes in a complete and accurate way, noting that the diabetes was consistently poorly controlled and poorly managed, and a condition which Dr. Cohen credibly opined directly impacted Petitioner's right shoulder condition. **Dr. Cohen was the only physician who thoroughly discussed and acknowledged the obvious and *very significant* lack of recitation of a work injury or work duties within the records. In fact, Dr. Wolin himself agreed there is no reference to Petitioner's work duties within anywhere in his charts** (Petitioner Dep. Exhibit 6, p.92) **Dr. Cohen was the only physician who reviewed a job description. Accordingly, there is ample reason to find and conclude the opinions of Dr. Cohen should be afforded more weight, credibility and reliance than those of Dr. Wolin.**

Compensation in this case is not supported by Commission precedent. In support, there are many prior Commission Decisions with similar backgrounds that have denied compensation; See *Leroy Hughes v. Provisto Township District 209*, 19 IWCC 115 (compensation denied on repetitive

trauma theory when evidence showed that Petitioner's job duties were varied throughout the day, and Petitioner's testimony that his diabetes was well-controlled was overwhelmingly contradicted by the medical records); *Christopher Breitbarth v. Pepsi*, 19 IWCC 124 (compensation denied on repetitive trauma theory where medical records demonstrated that Petitioner's job duties were varied throughout the day and initial medical records were silent on work); *Marsha Frazier v. Ventura Foods*, 11 IWCC 0080 (compensation denied on repetitive trauma theory when Petitioner's testimony regarding job duties was contradicted by the medical records, and Petitioner's treating physician premised his opinions on inaccurate information); *Greg Sylvester v. Gonnella Baking Co*, 19 IWCC 141 (compensation denied when Petitioner's treating physician premised his opinions on inaccurate information, and IME opinions were premised on a complete and thorough analysis of the medical records.)

In addition to the cases cited above, the Arbitrator also notes where the Commission cannot reconcile Petitioner's testimony with major inconsistencies and lack of support within the record, the Appellate Court has reversed its Decisions. See for example, *Orkin Exterminating Company v. Industrial Commission*, Ill.App.3d 753 (1988).

In this case, Petitioner's testimony at trial was entirely contradicted by the medical records, and Commission precedent does not support compensation. See *Lordine Davis v. Addus Healthcare*, 16 IWCC 284 (compensation denied when Petitioner told an entirely different story regarding her mechanism of injury than she did to her initial treating physicians) and *Gustavo Chavez v. Power Contracting and Engineering*, 16 IWCC 435 (compensation denied where Petitioner's testimony was entirely inconsistent with histories contained in the medical records and testimony of Respondent's witnesses).

As a final note, the Arbitrator finds it significant – and odd - that Petitioner does not appear to be alleging that his cervical condition is related to the claimed repetitive duties of his work. Petitioner testified regarding his right shoulder pain only, and did not address his cervical condition whatsoever, a condition which required extensive treatment before and after the alleged April 1, 2015 "manifestation date." Petitioner also never even attempted to designate which job duties were related to which condition, and Petitioner inexplicably never obtained an expert opinion regarding

the cervical spine condition. Finally, the Arbitrator notes that prior to seeing Dr. Wolin, Petitioner's physicians did not comment on his work status.

The Arbitrator notes that a long list of inferences and assumptions would need to be made in order to support a theory of compensability, but the record plainly does not offer any such evidence on which to draw any reasonable inferences in Petitioner's favor. Therefore, for the reasons set forth above, Petitioner's claim for compensation is denied.

In support of the Arbitrator's Decision with respect to (E) Notice, the Arbitrator makes the following findings and conclusions:

Having found in favor of Respondent on the issue of accident and causation, the Arbitrator further finds and concludes that Petitioner failed to give timely notice of his alleged injury to his employer. Despite finding no accident and causation, the Arbitrator makes the following comments on notice, only to illustrate the glaring lack of notice in the instant case.

Section 6(c) of the Act requires a claimant to provide notice of his injury to Respondent within 45 days of his accident or manifestation date. In this case at hand, first and foremost, **there was no evidence offered at all that Petitioner's alleged injuries occurred or manifested on April 1, 2015.** There is simply no evidence in the record agreeing with that claimed date whatsoever – **especially so even after Petitioner testified at trial and failed to offer testimony to support an April 1, 2015 accident date.**

Respondent introduced Time Logs contemporaneous with the alleged manifestation date (RX7). Based on the Time Logs, Petitioner worked before and after the manifestation date, up until at least August 21, 2015 (RX7). According to the logs, Petitioner did not even work on April 1, 2015 or April 2, 2015 (the logs notate unpaid time off on those days) and Petitioner resumed work thereafter with no interruption. (RX7)

Not only is the record utterly devoid of any connection between the alleged manifestation date and work, but the Arbitrator finds it significant that Petitioner – albeit in a very confused manner – offered no testimony that he specifically notified his employer about **any injury**. (T. 43-45) The Arbitrator notes that the mysterious "Mary" that allegedly ignored Petitioner's complaints was not present at trial and she did not appear to exist according to Respondent's credible witness Miguel

Valdes. It is entirely unknown what position "Mary" held, when she was allegedly notified about Petitioner's injuries, if at all, and what role she allegedly played in the injury reporting process.

On the other hand, Respondent witnesses offered credible and coherent testimony that Petitioner did not provide any notice of an injury, at any point throughout his employ with Respondent. Valdes stated that he (Valdes) was Petitioner's only supervisor at the time of the alleged onset, and that if an injury had occurred, he would have been the individual to be notified. (T. 82-83) Dawn Palella credibly testified that she first received notice of the alleged injuries in late April 2017, more than two years after the alleged manifestation date. **This testimony was unrebutted at trial**. (T. 103)

In connection with notice, the Arbitrator also finds it to be significant that these records reflect Petitioner *went directly into Employee Health* in May 2015, December 2015 and March, 2016, **with no recitation whatsoever of a workplace injury** within the notes from Employee Health, notes which were written by Respondent's credible witness Dawn Palella, and written at the time of the visits. (RX6)

In light of the foregoing, the Arbitrator finds and concludes Petitioner failed to give timely notice of his alleged injuries of April 1, 2015 to Respondent pursuant to Section 6(c) of the Act.

In support of the Arbitrator's Decision with respect to all other disputed issues, (J), (K), (L) and (O), the Arbitrator makes the following findings and conclusions:

Given that Petitioner has failed to meet his burden of proof regarding accident, causation and notice, the Arbitrator concludes that all other issues are moot.

Robert M. Harris

Robert M. Harris, Arbitrator
Dated: July 26, 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC003627
Case Name	BRITT, KEN v. GRANITE CITY SCHOOL DISTRICT
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	21IWCC0425
Number of Pages of Decision	5
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Matthew Terry

DATE FILED: 8/23/2021

/s/Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH BRITT,

Petitioner,

vs. NO: 18 WC 3627

GRANITE CITY SCHOOL DISTRICT,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Madison County, Illinois. In its August 10, 2020 Order, the Circuit Court affirmed in part and reversed in part the Commission's Decision dated November 21, 2019.

Procedurally, the parties proceeded with a Section 19(b) hearing as to the alleged injuries Petitioner sustained at work to his left shoulder, left elbow, and both knees on January 19, 2018. Respondent disputed causal connection after February 5, 2018 for Petitioner's left shoulder, left elbow, and left knee injuries, and disputed both accident and causal connection for Petitioner's claim to the right knee.

The Arbitrator issued his Decision on January 7, 2019, finding that Petitioner sustained an accident on January 19, 2018 that arose out of and in the course of his employment with Respondent. However, the Arbitrator found that Petitioner's current conditions of ill-being for his left shoulder, left elbow, and left knee were not causally related to the work injury. The Arbitrator only awarded medical bills through February 5, 2018. The Arbitrator additionally found that Petitioner failed to prove accident and causal connection for his alleged right knee injury and denied Petitioner's claim for the right knee in its entirety. The Arbitrator did not award any temporary total disability (TTD) benefits.

Petitioner filed his Petition for Review before the Commission. In its November 21, 2019 Decision, the Commission affirmed the Arbitrator in all respects but modified the Arbitrator's findings and award as it related to the alleged left knee injury. The Commission found that

Petitioner's current left knee condition was causally related to the January 19, 2018 work accident and awarded benefits. Specifically, the Commission awarded:

a) All reasonable, necessary, and causally related medical bills pertaining to the left knee;
b) The prospective treatment as may be recommended or reasonably required to cure or relieve Petitioner's left knee condition from the effects of the accidental injury; and,
c) Temporary total disability benefits of $659.46 per week for 36 5/7 weeks, commencing January 20, 2018 through October 3, 2018.

The matter was next reviewed by the Circuit Court of Madison County, Illinois. In its August 10, 2020 Order, the Circuit Court affirmed in part the Commission's Decision, but reversed as follows:

a) "The Court finds the Commission Decision ordering the District to 'pay all reasonable, necessary, and causally related medical bills pertaining to the left knee' is against the manifest weight of the evidence and is REVERSED AND REMANDED to the Commission to specify the exact dollar figure and dates of service the District is to pay and to whom for the medical bills pertaining to the left knee";
b) "The Court finds the Commission Decision that Britt is entitled to 'prospective treatment as may be recommended or reasonably required to cure or relieve Britt's left knee condition from the effects of the accidental injury' is against the manifest weight of the evidence and is therefore REVERSED and VACATED IN ITS ENTIRETY"; and,
c) "The Court finds the Commission Decision that Britt is entitled to 'temporary total disability benefits of $659.46 per week for 36 5/7 weeks, commencing January 20, 2018 through October 3, 2018' is against the manifest weight of the evidence and is therefore REVERSED and MODIFIED to Britt is entitled to 'temporary total disability benefits of $659.46 per week for 9 weeks, commencing January 20, 2018 through March 23, 2018.'"

Based upon the Circuit Court's remand Order, the Commission re-affirms the Arbitrator's finding that Petitioner sustained a work-related accident on January 19, 2018. The Commission also reinstates the Arbitrator's finding that Petitioner failed to prove that his current conditions of ill-being for his left shoulder, left elbow and left knee are causally related to the accident. The Commission additionally re-affirms the Arbitrator's finding that Petitioner failed to prove a compensable claim for his right knee and benefits as it relates to the right knee are denied in their entirety.

The Commission modifies and clarifies the Arbitrator's award of medical bills as instructed by the Circuit Court, and reverses the Arbitrator's denial of TTD benefits and instead awards TTD benefits from January 20, 2018 through March 23, 2018. The Commission also vacates its prior award of prospective medical. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of

compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 7, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay pursuant to Sections 8(a) and 8.2 of the Act the following reasonable, necessary, and causally related medical bills pertaining to the left shoulder, left elbow and left knee, incurred from January 19, 2018 through March 23, 2018:

a) Gateway Regional Medical: 1/19/2018 = $5,281.89
b) Multicare Specialists: 1/22/2018-3/22/2018 = $10,205.00
c) MRI Partners of Chesterfield: 1/24/2018 and 2/1/2018 = $15,789.12 (less $6,281.95 credit to Respondent)
d) Dr. Paletta: 2/5/2018 = $823.00 (less $94.82 credit to Respondent)
e) NEI Inc. of Saint Louis: 2/13/2018 = $2,714.00

The Commission notes that the medical bills from Gateway Regional and Multicare Specialists were paid in part by the group carrier. The Commission therefore finds that Respondent is entitled to a credit pursuant to Section 8(j) of the Act for these bills. Respondent shall also hold Petitioner harmless for any claims for reimbursement from any health insurance provider.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for prospective medical related to the left knee is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $659.46 per week for 9 weeks, commencing January 20, 2018 through March 23, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $9,891.90 for temporary total disability benefits that were previously paid to Petitioner.

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

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

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

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

August 23, 2021

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

CAH/pm
D: 8/19/2021
052

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC034802
Case Name	ZIEMBA, MICHAEL v. POWER CONSTRUCTION CO LLC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0426
Number of Pages of Decision	3
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	Brian Koch

DATE FILED: 8/23/2021

/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 clarification	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL ZIEMBA,
Petitioner,

vs. No: 15 WC 34802

POWER CONSTRUCTION CO. LLC.,
Respondent

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Review of the Arbitrator's denial of his Petition for Reinstatement of his Claim. According to the official records of the Commission, Petitioner filed his Application for Adjustment of Claim on October 28, 2015. He alleged an accident date of September 4, 2015 and injuries sustained to his right shoulder. The official records of the Commission also indicate that Arbitrator Stephenson dismissed the claim on July 28, 2020 for want of prosecution.

On January 13, 2021, Petitioner filed the instant Petition to Review the Arbitrator's denial of his Petition to Reinstate his claim. However, the official records do not show Petitioner filed a motion to reinstate his claim or that the Arbitrator denied any such motion. There is no indication that any written order memorializing the dismissal or the denial of Petitioner's Motion to Reinstate was entered. Similarly, there is no indication that there was any hearing held on the Motion to Reinstate and there is no transcript of any such hearing before the Commission. Despite the lack of a record, Respondent does not dispute that Petitioner filed a Motion to Reinstate or that the Arbitrator denied it. Therefore, it appears that any order of dismissal and order denying Petitioner's Motion to Reinstate were oral.

Commission rule 7020.90 requires that the Arbitrator apply standards of fairness and equity in ruling on a Petition to reinstate and shall consider the grounds relied on by Petitioner, the objections of Respondent and the precedents set forth in Commission decisions. Because we have no written order or transcript of proceedings upon which any decision was based, the Commission has no basis to review the apparent Decision of the Arbitrator to deny Petitioner's Petition to Reinstate. Without any such information, the Commission cannot determine the appropriateness of the Arbitrator's actions. Therefore, the Commission remands this matter back to the Arbitrator for a hearing and a written order disposing of Petitioner's Petition to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that matter be remanded back to the Arbitrator to conduct a hearing and to issue a written order disposing of Petitioner's Petition to Reinstate.

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

August 23, 2021

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

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

DLS/dw
R-7/14/21
46

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC005426
Case Name	RHOADES, JOHN v. INTERNATIONAL PAPER COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0427
Number of Pages of Decision	33
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Daniel Jones
Respondent Attorney	Jennifer Weller

DATE FILED: 8/23/2021

/s/ Deborah Simpson, 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: PPD	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN RHOADES,

Petitioner,

vs. NO: 14 WC 5426

INTERNATIONAL PAPER COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. Findings of Fact

Petitioner was employed as a maintenance mechanic for Respondent with job duties that entailed keeping the Paper Machinery Corporation machines running through preventative maintenance. Each machine was composed of thousands of moving parts varying in size from 100 to 150-pound turrets to small stamp-sized pieces of metal. In the completion of his duties, Petitioner used both big and small hand tools and pushed his 900-pound toolbox on wheels from one end of the plant to the other every night to work on the machines.

Each time Petitioner worked on a machine, he had to get inside it, which required standing, squatting, and moving into odd angles. Petitioner had to stand the entire night, except for when he was laying on his back underneath a machine. While completing this work, Petitioner's arms were positioned either in front of him or up over his head.

On March 29, 2011, Petitioner received a work order to take apart a machine that was waist-high with a set of non-attached stairs that slid out from under it. Petitioner climbed onto the stairs to take parts off the machine. After Petitioner removed a turret, there was a steel shaft beside it that was the width of his thumb and stuck up at least a foot from the bottom of the turret. When

Petitioner attempted to take the sleeve off over the shaft, the stairs slipped out from under his foot and all his weight fell forward, causing the steel shaft to impale his upper lip and hit his teeth. Following this incident, Petitioner claimed injuries to his head and neck as well as headaches and upper and lower extremity numbness.

Petitioner promptly presented to Shelby Memorial Hospital on the accident date with complaints of neck pain and stiffness. The emergency room doctor observed a vertical laceration measuring 1.5 centimeters on Petitioner's upper lip that was superficial and not bleeding. Petitioner's lip was sutured, and he was diagnosed with an upper lip laceration with facial contusion. Shortly thereafter, on March 31, 2011, Petitioner presented to Hastings Dental Clinic and reported hitting his teeth when he fell and chipping the incisal edge of a tooth. This resulted in Petitioner receiving a filling on April 7, 2011. At that time, Petitioner also reported that two of his teeth were slightly long and hitting against the lower anterior teeth.

Upon referral from Dr. Hastings, Petitioner saw Dr. J. Michael Hudson of Hudson Orthodontics on April 13, 2011. Dr. Hudson noted that Petitioner had cluster headaches and TMJ. Petitioner thereafter treated with Dr. Hudson through December 2013 and received braces.

On May 13, 2011, Petitioner presented to Pana Medical Group and reported taking diltiazem for migraines. Prior to the accident, Petitioner had a history of migraines that dated back to his teenage years and occurred on and off. Pre-accident records show that Petitioner saw Dr. Rana Mahmood on November 12, 2018 for his longstanding headaches. Dr. Mahmood's diagnosis was migraines with aura that were likely due to olfactory hallucination. He prescribed Relpax and Inderal for prophylaxis. Dr. Mahmood also ordered an EEG, which yielded normal results on November 18, 2018. Dr. Mahmood later continued Petitioner's prophylactic medication and further prescribed abortive therapy medication on December 9, 2009. However, he eventually recommended tapering off the medications on January 21, 2010 after Petitioner expressed concern that they were making his headaches worse.

The last pre-accident treatment note concerning Petitioner's headaches was from Taylorville Memorial Hospital on February 7, 2010, which was over 13 months before the work accident. For a migraine headache, Dr. David Harvey ordered Toradol and Compazine injections as well as Dilaudid. Petitioner testified that he thereafter did not have any problems with headaches in the 13 months before his accident. Petitioner explained that Dr. Mahmood had put him on blood pressure medicine that seemed to take care of his migraines completely.

Petitioner resumed treatment for his headaches post-accident with Dr. Quizon on May 13, 2011. Shortly thereafter, on May 23, 2011, Dr. Hudson wrote Respondent a letter noting that Petitioner was having severe headaches. Dr. Hudson further opined that Petitioner had a traumatic occlusion of his incisors and anterior crossbite consistent with his work injury. He made Petitioner a lower occlusal splint and recommended braces.

On July 8, 2011, Dr. Quizon kept Petitioner on diltiazem and indicated that he could return to work after Petitioner had reported missing work two days prior for a severe headache. When he returned on July 15, 2011, Petitioner told Dr. Quizon that he had missed a lot of work lately and was sent home yesterday due to a headache. Dr. Quizon's assessment was recurrent migraine

headaches with cluster headaches. He prescribed a Medrol Dosepak, continued the diltiazem prescription, and returned Petitioner to work as of July 16.

On August 4, 2011, Dr. Hudson indicated that Petitioner's headaches might not feel better until his crossbite was jumped. Petitioner then reported to Dr. Quizon on August 5, 2011 that he had missed several days of work with recurrent headaches. Dr. Quizon referred Petitioner back to Dr. Mahmood, who Petitioner saw on August 10, 2011. Dr. Mahmood recommended Botox therapy along with medication. Subsequently, on August 24, 2011, Dr. Mahmood further prescribed Topamax, Vistaril, and a Medrol Dosepak.

On October 5, 2011, Petitioner reported that his headaches were better, but he had numbness and tingling in his hands, feet, and face that began two weeks after he started taking Topamax. Dr. Mahmood advised Petitioner to gradually taper off Topamax. He also indicated that Petitioner's braces might be helping with his headaches; however, it represented a temporary fix. On October 19, 2011, Petitioner returned to Dr. Quizon and reported that his headaches were much better after his teeth got fixed. Dr. Quizon's assessment was an improved history of migraine headaches. However, when Petitioner next saw Dr. Quizon on November 4, 2011, he reported that he had missed work on October 20 and had been back to work on and off. Petitioner requested, and was given, a return to work slip for the following day.

On December 1, 2011, Petitioner presented to Dr. Pavinderpal Gill at the Springfield Clinic with complaints of headaches, neck pain, neck crackling, and upper extremity numbness. Dr. Gill noted that Petitioner's headaches initially resolved after he was given braces but had since recurred and were debilitating. Dr. Gill diagnosed Petitioner with headaches of an unclear etiology. He stated that Petitioner could have suffered an aggravation of his migraines or cluster headaches from his work injury, which also possibly resulted in TMJ syndrome. A work status note was provided stating that Petitioner had been unable to work from November 17, 2011 to December 2, 2011 but could return to work without restrictions on December 5, 2011.

Cervical and TMJ X-rays were also obtained on December 1, 2011. The cervical X-rays showed mild C5-C6 disc space narrowing with minimal retrolisthesis, moderate C6-C7 disc space narrowing with anterior osteophytosis, and possible mild right C6-C7 neural foraminal narrowing. The TMJ X-rays revealed bilateral sublux with opening.

On December 4, 2011, Petitioner told Dr. Hudson that he had no headaches for one and a half months after his braces were placed, but he was again experiencing debilitating headaches and could hardly get out of bed. Petitioner followed up for his headaches with Dr. Gill on December 15, 2011. Dr. Gill diagnosed Petitioner with benign essential hypertension and started him on Bystolic. He also ordered CTs of Petitioner's head, neck, and TMJs, which were obtained on December 16, 2011. The head CT was negative. However, the cervical CT showed moderate lower cervical degeneration and the face CT showed left greater than right mild chronic maxillary sinusitis with no facial fractures.

On December 21, 2011, Dr. Gill listed Petitioner's active problems as benign essential hypertension, cervicalgia, a facial injury, headaches/migraines, and occipital neuralgia. On February 2, 2012, Petitioner returned to Dr. Gill to have his medications refilled. Dr. Gill kept

Petitioner on Bystolic for his benign essential hypertension. He further noted that Petitioner had chronic neck pain and headaches.

When Petitioner subsequently saw Dr. Hudson on May 30, 2012, he reported having no headaches since 2012 started, except for possibly a small one. Petitioner was on no medication for his headaches at that time. On July 24, 2012, Dr. Hudson again noted that Petitioner had no headaches and was on no headache medication. Dr. Hudson then removed Petitioner's braces on August 22, 2012. Shortly thereafter, on August 30, 2012, Petitioner told Dr. Hudson that his headaches had returned and that he had suffered from a headache every day since the Saturday after his braces were removed. Petitioner also informed Dr. Gill on August 31, 2012 that his headaches had recurred following the removal of his braces. Dr. Gill indicated that Petitioner's long-standing headaches were multifactorial. A work status note from this visit also took Petitioner off work from August 28 to August 29. On September 24, 2012, Springfield Clinic provided another work status note indicating that Petitioner had been unable to work from September 20 to September 23 due to recurring headaches.

From an orthodontic perspective, Dr. Hudson then provided a work status note on October 1, 2012 stating that Petitioner could work without restrictions. He also put Petitioner at MMI, although he noted that Petitioner would need to wear a retainer at night for the rest of his life. Nevertheless, on October 8, 2012, Dr. Gill filled out FMLA paperwork indicating that Petitioner had headache flareups every so often where he could not work.

On October 11, 2012, a cervical MRI revealed significant degenerative changes with canal and foraminal stenosis at C5-C6 and slightly less prominent degenerative changes at C6-C7 with no evidence of an acute injury. Then, on October 17, 2012, Petitioner informed Dr. Gill that his headaches had flared up and worsened. Petitioner was treated for his headaches, as well as some chest pain, at this visit as well as his follow-up visit on October 22, 2011. Dr. Gill released Petitioner back to work without restrictions as of October 23, 2011 but also provided an off-work note indicating that Petitioner was previously unable to work from October 15 to October 22.

Petitioner then returned to Dr. Hudson for a retainer check on October 30, 2012, at which time Dr. Hudson reported that Petitioner's jaw popped a lot and sometimes locked. On November 8, 2012, Dr. Gill indicated that Petitioner was also suffering from ongoing cervical issues for which he provided a referral to Dr. Leslie Acakpo Satchivi of the Springfield Clinic. Petitioner presented to Dr. Satchivi on November 20, 2012 with complaints of neck pain off and on since his work accident with associated headaches and bilateral arm numbness. Cervical X-rays were obtained and revealed degenerative disc space narrowing at C5-C6 and C6-C7. Dr. Satchivi diagnosed Petitioner with cervical spondylosis and noted that his work injury possibly involved hyperextension of the cervical spine. Nevertheless, Dr. Satchivi found that Petitioner had a normal neurological examination. As such, he recommended exhausting conservative measures with prednisone, Toradol, Naprosyn, and physical therapy.

On January 14, 2013, Petitioner returned to Dr. Hudson and reported that his headaches were much better. Dr. Hudson noted that although Petitioner still had popping, it was also improved. He instructed Petitioner to continue wearing his retainers.

Over a year and a half later, on September 23, 2014, Petitioner presented to Dr. Satchivi with complaints of radiating neck pain, as well as bilateral upper and lower extremity numbness. Dr. Satchivi stated that although Petitioner complained of worsening symptoms, he continued to have a normal neurological examination. Upon Dr. Satchivi's recommendation, a cervical MRI was obtained on September 24, 2014. It revealed severe degenerative disc disease at C5-C6 and C6-C7 with spinal stenosis, mild to moderate cord impingement, and severe bilateral foraminal narrowing. On September 30, 2014, Dr. Satchivi diagnosed Petitioner with cervical spondylosis without myelopathy or radiculopathy. Based on the MRI results, Dr. Satchivi recommended a C5-C6 and C6-C7 anterior cervical discectomy with fixation and fusion. Petitioner thereafter underwent the surgery on October 13, 2014.

On October 24, 2014, Petitioner followed up with Dr. Satchivi and indicated that he was pleased with the surgical results. Petitioner reported that his pain, numbness, tingling, and range of motion was much improved. Dr. Satchivi cleared Petitioner to resume driving and his activities of daily living without lifting greater than 20 pounds.

Petitioner then presented to Taylorville Memorial Hospital on November 24, 2014 with a foot injury. Petitioner reported that following his neck surgery in October, he had six to eight episodes a day of numbness and tingling in all four extremities. Petitioner stated that he had an episode while he was in the kitchen where his arms began to go numb and he went to sit down, but he did not make it to the chair and instead fell and twisted his ankle. Petitioner was diagnosed with acute right foot pain with a right distal fibular fracture. He was instructed to take Tylenol or Motrin as needed and remain weightbearing as tolerated.

Thereafter, on December 2, 2014, Dr. Satchivi indicated that Petitioner had begun to experience upper and lower extremity numbness once again three weeks out from his surgery. Petitioner reported that these episodes usually occurred with flexion of the neck for 20 or 30 minutes, such as when he was sitting down and working. Dr. Satchivi stated that he was pleased overall with Petitioner's recovery, but he was at a loss to explain Petitioner's intermittent numbness with neck flexion, except to hypothesize that it might be a reflection of a previous injury to the spinal cord that was still in the process of healing.

On January 13, 2015, Dr. Satchivi reported that Petitioner was doing well with resolved pain and improved range of motion. However, Petitioner continued to have one to two episodes a week of numbness in his arms and legs after his neck was flexed for an extended period. Nevertheless, Dr. Satchivi reported that Petitioner was ready to get back to working out and planned to search for a new job. He indicated that Petitioner had no restrictions at this point.

Petitioner next saw NP Stephanie Solomon of the Springfield Clinic on April 23, 2015, at which time Petitioner continued to report upper and lower extremity numbness that occurred when he was standing and looking down. On examination, Petitioner's cervical range of motion was intact. A cervical X-ray further revealed a stable fusion at C5 to C7 without evidence of hardware complication, significant anterolisthesis or retrolisthesis, or instability. NP Solomon indicated that Petitioner could now follow up as needed. Although she agreed that Petitioner could still be experiencing residual symptoms due to his spinal cord injury, NP Solomon believed that the symptoms would continue to improve with time.

On August 4, 2015, Petitioner returned to Dr. Satchivi and complained of more pain and tightness in his neck along with numbness in his arms, hands, and feet. Petitioner also reported having more headaches and dropping things. Dr. Satchivi stated that he was unsure what to make of Petitioner's symptoms and he could simply be experiencing deconditioning. Nevertheless, he determined that Petitioner would likely benefit from physical therapy and massage therapy.

On August 6, 2015, Petitioner underwent a cervical MRI that revealed mild degenerative disc and joint disease, bony ridging at C5-C6 and C6-C7 resulting in up to moderate foraminal narrowing, small central disc protrusions at C3-C4 and C4-C5, and progressed mild to moderate C7-T1 facet arthropathy. On August 12, 2015, Dr. Satchivi noted that the MRI revealed no evidence of hardware failure. He also stated that the patency of the spinal canal and neural foramina at C5-C6 and C6-C7 was much improved from Petitioner's preoperative study.

Petitioner thereafter participated in physical therapy for his cervicalgia from August 18, 2015 through October 8, 2015, at which time he was discharged for having plateaued. Petitioner then returned to Dr. Satchivi on October 23, 2015 and indicated that he continued to have bilateral hand numbness when he held his arms up for longer than 15 minutes. Additionally, Petitioner reported that his neck pain and headaches were again worsening, although his movement and range of motion remained intact. Dr. Satchivi's diagnosis was cervicalgia. He recommended another cervical MRI, which was obtained on October 28, 2015. The MRI showed a small C4-C5 protrusion with mild canal stenosis, endplate osteophyte with mild canal stenosis at C6-C7, and multilevel uncovertebral spurring with the most stenosis at the right C5-C6 and C6-C7 foramina.

Petitioner was then seen by NP Chris Carver at the Springfield Clinic on November 10, 2015. Petitioner reported that he had decreasing hand grasp daily and increasing numbness when he tried to use his hands or tools. He also complained of occasional lower extremity weakness and an almost constant daily headache. NP Carver opined that the prolonged time between Petitioner's diagnosis and the neck surgery may have contributed to his current numbness and tingling. NP Carver also offered Petitioner gabapentin or a mild pain medication for his headaches, but Petitioner stated that he did not wish to take medication due to his family history of drug addiction.

Also on NP Carver's recommendation, Petitioner underwent an upper extremity EMG on November 30, 2015. The EMG revealed bilateral C6 radiculopathies with reinnervation and mild bilateral median neuropathies at the wrists without interval change from the prior EMG. It was further noted on the EMG report that Petitioner's intermittent bilateral arm numbness extending from the shoulder to the hand could reflect residual radiculopathy versus carpal tunnel syndrome. On January 12, 2016, Dr. Gill noted that Petitioner's EMG showed mild bilateral carpal tunnel syndrome and some C6 radiculopathy. However, Petitioner's assessment at this visit instead focused on his benign essential hypertension and elevated liver enzymes.

Petitioner thereafter presented for a §12 examination with Dr. Brandon Larkin, a primary care sports medicine specialist, on September 7, 2017. Dr. Larkin found that Petitioner's head and neck injury had resulted in an activation of preexisting cervical degenerative joint disease with resultant bilateral radiculopathy. He indicated that Petitioner had also sustained a dental injury that required corrective orthodontics and a facial laceration that healed without issue. Moreover,

Dr. Larkin found that Petitioner was suffering from bilateral upper extremity numbness that was likely secondary to a cervical nerve root injury and posttraumatic intractable headaches. He stated that although migraine headaches could be an appropriate diagnosis for some of Petitioner's symptoms, he also appeared to be suffering from a bilateral third occipital neuralgia.

Dr. Larkin opined that the work accident was the primary factor causing Petitioner's medical conditions. Since Petitioner described no prior history of pain, numbness, or tingling in his arms, Dr. Larkin indicated that the accident had activated pain and numbness symptoms that had not previously been present. Dr. Larkin estimated that Petitioner's continued upper extremity numbness and tingling resulted in a 10% permanent partial disability of which 66% was due to the work injury and 33% was due to underlying cervical degenerative changes.

As for Petitioner's headaches, Dr. Larkin opined that the work injury was 100% the prevailing factor in his disability. However, he indicated that a discussion of permanent partial disability was premature because further treatment was required. Dr. Larkin recommended injections to the third occipital nerve, because he found Petitioner's examination to be consistent with prolonged and chronic suboccipital neuralgia.

When Dr. Larkin was deposed on April 19, 2018, he testified consistently with his §12 report. Regarding the bilateral upper extremity numbness, Dr. Larkin further testified that Petitioner had a permanent disability of moderate severity that manifested itself in significant difficulties with lifting his arms, holding or carrying objects, and driving longer than a few minutes. Dr. Larkin also testified that Petitioner's disabilities prevented him from working as a maintenance mechanic and affected his ability to work on machinery, lift heavy objects, and use tools. He testified that Petitioner would have trouble with physical labor; however, he could tolerate desk work, typing, and activities that did not require a lot of lifting and arm movement.

Dr. Russel Cantrell, a board certified physician who specializes in physical medicine and rehabilitation, also performed a §12 examination on July 22, 2019. Dr. Cantrell reported that Petitioner had denied having any headaches in the one or two years before his accident; however, Dr. Cantrell believed this statement was inconsistent with the medical records that showed he treated as recently as February 2010. Dr. Cantrell found that Petitioner's diagnoses could best be described as subjective complaints of headaches, subjective complaints of neck pain, and subjective complaints of bilateral upper extremity numbness. Dr. Cantrell further opined that Petitioner did not require any further evaluation or treatment for his work injury. At the hearing, Petitioner indicated that he was stipulating to the MMI date of July 22, 2019 from Dr. Cantrell.

On August 27, 2019, Dr. Cantrell authored an addendum regarding Petitioner's work status. Dr. Cantrell opined that Petitioner did not require any permanent work restrictions. He based this on Petitioner having performed his regular work activities leading up to his cervical fusion and on his finding at the §12 examination that Petitioner had no objective findings to explain the ongoing nature of his subjective complaints.

When the parties deposed Dr. Cantrell February 6, 2020, he testified consistently with his reports. Dr. Cantrell further testified that based on his physical examination, there were no findings that would support or explain Petitioner's complaints of bilateral upper extremity numbness and

tingling. Dr. Cantrell also did not see evidence of any cervical radiculopathy and called Petitioner's examination neurologically unremarkable. Nevertheless, Dr. Cantrell testified that it was possible that Petitioner's symptoms were related to carpal tunnel syndrome. However, he testified that even that diagnosis did not explain the numbness in the entirety of Petitioner's arm, because the median nerve does not supply the entirety of sensation to the upper extremities.

On cross examination, Dr. Cantrell conceded that he did not know what specific activities Petitioner performed as a mechanic; however, he testified that he could still opine that Petitioner did not require any permanent restrictions based on his examination as well as the fact that Petitioner was doing his regular work activities for a year or longer following his work injury. As such, Dr. Cantrell testified that Petitioner had already functionally demonstrated the ability to perform his regular work activities and there was no reason to believe that the fusion had caused a diminishment in his functional capabilities.

At the hearing, Petitioner clarified that after the accident, he went back to full duty work. Although he periodically missed a couple days here and there due to headaches or doctors' appointments, Petitioner continued to work full duty until his termination on November 11, 2012. Petitioner testified that Respondent fired him for allegedly breaking a machine, even though the machine was already broken when he was told to work on it. Petitioner then filed for unemployment in 2013. Petitioner did not recall what dates he received the unemployment benefits, but he estimated that it lasted for about six months. Petitioner recalled signing a statement indicating that he was ready, willing, and able to work in order to receive the unemployment benefits.

Petitioner testified that he applied for a few jobs in 2012 or 2013, but he had to be honest with the employers about the shape he was in. Petitioner did not recall any of the places where he filled out applications and did not go on any interviews. He indicated that he did have a couple phone calls regarding the applications in 2013, but he did not recall with whom. Petitioner has not looked for a job since 2013 nor performed any work that generated income since November 2012.

Petitioner testified that he did not see how he could possibly get a job and who would hire him in his current condition. He testified that he had to be honest with anyone that interviewed him regarding what was wrong and how he could not do the work he did prior. He testified that he could not hold hand tools for more than ten minutes or do the fine hand-eye coordination work that he did for Respondent. Petitioner did not think he could do any physical labor job. Additionally, he testified that he could not do any computer work, because he could not be on his home computer for more than ten minutes without his arms going numb.

Prior to working for Respondent, Petitioner attended Millikin University for two years but had to quit so he could work full time to take care of his parents. He did not obtain a degree and had no other formal education. Prior to becoming a mechanic, Petitioner also worked as a pressman and ran the printing press for several newspapers. Although he was originally hired as a pressman's apprentice by Respondent in 2006, he became a mechanic three months later.

Petitioner further testified that his current headaches were more intense than his pre-accident headaches. He explained that the prior headaches came mostly from the front and temple

areas, whereas his post-accident pain was all throughout, especially from the back of his head to the sides and across the top. Petitioner testified that his headaches and neck pain eventually affected his ability to work, as the pain became too much to work through. He testified that when he missed work, it would be for a few days to try to get through the headaches.

Petitioner testified that he still experienced constant headaches everyday and had no quality of life. Nevertheless, he was on no medication for his headaches or neck pain at the time of the hearing, except for blood pressure medicine that he also took before his accident.

Although his leg numbness ceased six months post-surgery, Petitioner still also had arm and hand numbness when he did anything with his hands in front of him, including driving, pushing or riding his lawn mowers, preparing food, or working on his computer. Petitioner testified that if he had his hands in front of him for ten to 15 minutes, his arms went numb and he could not move or feel them. Petitioner testified that he hurt his hands several times by holding onto a glass and squeezing it, because he could not feel how hard he was gripping.

Petitioner further testified that he could no longer drive himself. Instead, his daughter drove him around most of the time, and there were several occasions when his 80-year-old mother had to drive him to the doctor since his daughter had to work. Petitioner further testified that his balance was off, he often got dizzy, and he had everyday neck pain that shot through his head. Regarding his TMJ, Petitioner testified that his jaw also still made noises and hurt every time he ate and opened his mouth wider than just for talking.

II. Conclusions of Law

Following a careful review of the entire record, the Commission finds that Petitioner failed to establish his entitlement to a §8(d)1 wage differential award. For a wage differential award, Petitioner must prove both a partial incapacity that prevents him from pursuing his usual and customary line of employment and an impairment of earnings. *Copperweld Tubing Products v. Comm'n*, 402 Ill.App.3d 630, 633 (1st Dist. 2010).

The Commission finds that Petitioner falls short of proving that he had a partial incapacity that prevented him from pursuing his usual and customary line of employment. Following his accident, Petitioner returned to work full duty at his physically demanding job and remained working full duty at the time of his termination on November 11, 2012. Although Petitioner indicated that he occasionally missed days of work due to his headaches, he was under no work restrictions from his treating doctors until the cervical surgery on October 13, 2014. Thereafter, Petitioner was again returned to work with no restrictions by Dr. Satchivi on January 13, 2015. Petitioner was given no permanent restrictions from his treating doctors and demonstrated his post-accident ability to work full duty in a very physically demanding job.

Nevertheless, Dr. Larkin opined that Petitioner's disabilities prevented him from working as a maintenance mechanic and affected his ability to work on machinery, lift heavy objects, and use tools. Dr. Larkin testified that Petitioner would have trouble with such physical labor; however, he could tolerate desk work, typing, and activities that did not require a lot of lifting and arm movement. However, given that Petitioner continued to work full duty without restrictions

up until his termination, the Commission is not persuaded by Dr. Larkin's opinion.

Moreover, the Commission finds that Petitioner failed to demonstrate an impairment of earnings. No labor market survey was provided, and Petitioner had not applied for any jobs since 2013. Although he had applied for a few jobs in 2012 or 2013, Petitioner did not recall where he filled out the applications and did not go on any interviews. He also could not recall who he had phone conversations with regarding his applications. There was no information provided as to what kind of jobs Petitioner had applied to or how much these jobs paid. As such, the Commission finds that an impairment of earnings was not established.

The Commission accordingly vacates the Arbitrator's §8(d)1 wage differential award. Nevertheless, the Commission finds that a permanent partial disability award is warranted and modifies the Decision of the Arbitrator to find that Petitioner sustained a loss of 40% PAW based upon its analysis of the §8.1(b) statutory factors.

In reviewing permanent partial disability for accidents occurring after September 1, 2011, the Commission must consider the §8.1(b) enumerated criteria, including (i) the reported level of impairment pursuant to (a) [AMA "Guides to Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability as corroborated by treating medical records. 820 ILCS 305/8.1b(b). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id*. § 305/8.1b(b)(v).

Regarding criterion (i), Dr. Larkin, although not clear as to whether he was providing an AMA impairment rating, opined that Petitioner's upper extremity numbness and tingling had resulted in a 10% permanent partial disability of which 66% was due to the work injury and 33% was due to his underlying cervical degenerative changes. The Commission assigns some weight to this factor.

Regarding criterion (ii), Petitioner was a machine mechanic on the accident date. Following his accident, he returned to work full duty and remained working at a full duty capacity at the time of his termination on November 11, 2012. During that period, Petitioner testified that he periodically missed a couple days of work here and there due to headaches or doctor's appointments, but for the most part, he continued to work full duty for Respondent. After his termination, Petitioner underwent a cervical surgery on October 13, 2014 and was placed under restrictions until January 13, 2015, at which time Dr. Satchivi determined that Petitioner no longer required restrictions. The Commission assigns significant weight to this factor.

Regarding criterion (iii), Petitioner was 43 years old on the accident date. No direct evidence was presented as to how Petitioner's age specifically affected his disability. The Commission assigns some weight to this factor.

Regarding criterion (iv), Petitioner had not worked for any other employer since he was terminated by Respondent on November 11, 2012 and had not looked for another job since 2013. Although Petitioner testified to applying to a few jobs in 2013, he did not recall the names of any of the places where he filled out applications. There was no information provided as to what kind

of jobs Petitioner had applied to and how much these jobs paid. No labor market survey was obtained either. Additionally, there was conflicting evidence as to whether Petitioner was physically capable of performing computer work. Dr. Larkin testified that Petitioner could tolerate desk work, typing, and activities that did not require a lot of lifting and arm movement. However, Petitioner testified that he could not be on a computer for more than ten minutes without his arms going numb. The Commission assigns moderate weight to this factor.

Regarding criterion (v), Petitioner required a C5-C6 and C6-C7 anterior cervical discectomy with fixation and fusion, dental work and braces, facial sutures, physical therapy, medication, and work restrictions to treat his injuries.

Regarding his headaches, Petitioner testified that he still suffered from constant headaches everyday all day and had no quality of life as a result.

Regarding his extremity numbness today, Petitioner testified that his bilateral leg numbness was gone within six months after his cervical surgery, but he still had arm numbness if he did anything with his hands out in front of him, including driving, pushing or riding his lawn mowers, preparing food, or working on his computer. If he did something with his hands in front of him for ten to fifteen minutes, his arms went numb and he could not move or feel them. Petitioner also hurt his hands several times by holding onto a glass and squeezing it too hard, because he could not feel the strength of his grip.

Regarding his current neck and head issues, Petitioner testified that he had everyday neck pain that shot through his head, he got dizzy, and his balance was off. As for his TMJ, Petitioner testified that his jaw continued to make noises and hurt every time he ate and if he opened it wider than for just talking. Additionally, after being put at MMI for his dental injury, Dr. Hudson indicated that Petitioner needed to wear a retainer at night for the rest of his life and return for retainer checks.

Petitioner further testified that his daughter drove him around most of the time, and there were several occasions where his 80-year-old mother had to drive him to the doctor when his daughter had to work. Nevertheless, the treatment records do not show that Petitioner was under any driving restrictions. After his cervical surgery, Dr. Satchivi cleared Petitioner to drive as of October 24, 2014.

Despite his ongoing pain, Petitioner currently takes no medication for his neck pain or headaches. However, he took blood pressure medicine before his accident and remained on blood pressure medicine at the time of the hearing.

Upon consideration of these factors, the Commission finds that Petitioner sustained a loss of 40% PAW for his injuries. Although Petitioner returned to his full duty job prior to his termination, he continues to experience ongoing headaches, neck pain, and upper extremity numbness that affects his daily life. The Commission modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the

Arbitrator filed October 26, 2020 is modified as stated herein. For all other issues not specifically modified herein, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED that the Arbitrator's wage differential award under §8(d)1 of the Illinois Workers' Compensation Act is vacated. Nevertheless, for Petitioner's ongoing headaches, neck pain, upper extremity numbness, and TMJ condition, the Commission orders Respondent to pay the sum of $354.73 for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a loss of 40% PAW.

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

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

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.

August 23, 2021

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

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

DLS/met
O- 6/22/21
46

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0427
NOTICE OF ARBITRATOR DECISION

RHOADES, JOHN Case# **14WC005426**
Employee/Petitioner

INTERNATIONAL PAPER COMPANY
Employer/Respondent

On 10/26/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2847 TAPELLA & EBERSPACHER LLC
DANIEL C JONES
PO BOX 627
MATTOON, IL 61938-0627

5332 GOLDBERG & SEGALLA LLP
JENNIFER WELLER
8000 MARYLAND AVE SUITE 640
ST LOUIS, MO 63105

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

John Rhoades
Employee/Petitioner

v.

International Paper Company
Employer/Respondent

Case # 14-WC-005426

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **August 26, 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 or about **March 29, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $44,948.80; the average weekly wage was $864.40.

On the date of accident, Petitioner was **43** years of age, **single** with **1** dependent children.

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

Respondent **has not** stipulated it will pay all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit for TTD paid from April 19, 2018, through July 22, 2019 for TTD, **$0** for maintenance, and **$0** for an advancement of PPD, for a total credit of **$0**.

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

ORDER

FACTS

On March 29, 2011, Petitioner, JOHN RHOADES, was employed as a maintenance mechanic for Respondent, International Paper Company in Shelbyville, Illinois (Tr. p. 9; Arb. Exh. 2). On that date, he had earned $44,948.80 in the year prior, and had an Average Weekly Wage of $864.40 (Tr. p. 9; Arb. Exh. 1). He attended Millikin University for 2 years, but was forced to quit school to take care of his parents when his father got cancer, and he never completed his degree from Millikin (Tr. p. 10). He worked for several newspapers after that as a pressman running a printing press and printing newspapers (Tr. pp. 10-11). In 2006, he applied for a pressman's position with Respondent, but that position was not open at the time, and he started as a pressman's apprentice (Tr. p. 11). Three months' later, he took the mechanic's test for an open position, and was told by two supervisors that he had one of the highest scores they had ever had on the mechanics' test, and they wanted him to take the position immediately (Tr. p. 12). He has no formal training as a mechanic (Tr. p. 12).

International Paper makes cups and plates, mostly paper cups for the food service industry (Tr. p. 11). The entire plant covers 3 city blocks (Tr. p. 18). It prints and makes the cups – printing the paper, cutting the paper, and making the cups (Tr. p. 13). The paper is covered in large rolls with a polymer plastic coating (Tr. p. 16). The rolls are then cut into cups shapes, and each of the cup shapes are put together by placing them on a machine, around a turret, and then applying heat at the spots where seams would be on the bottom and side (Tr. p. 16).

When he became a mechanic at International Paper, Petitioner was trained for several functions, but specifically trained to service machines made by Paper Machinery Corporation, which printed over 300 cups per minute (Tr. pp. 12-13). These machines are each between 15 and 20 feet long, 6 to 7 feet high, and 8 feet wide, and are enclosed by a cage so that no one can get into the moving parts when the machine is running (Tr.

p. 13). There were approximately 76 such machines at International Paper, and were placed in at least 12 "cells" of 6 to 8 machines per cell (Tr. p. 14).

Petitioner's job was to keep the machines running during his shift through preventative maintenance (Tr p.14). Everything he did required detailed hand/eye coordination (Tr. p. 15). Each machine had thousands of moving parts, and if he took any piece of the machine apart and put it back together, he had to make sure everything was calipered exactly right to make sure none of the moving parts would stop up or rub together (Tr. p. 15). These machine parts varied in size from a 100 to 150 pound turret to stamp-sized pieces of metal that had to fit together perfectly with screws, and he was required to handle them all (Tr. pp. 15-16). His work involved the repeated twisting of the wrist, as he needed to use big and small hand tools all the time (Tr. p. 17). He kept his tools in a multi-leveled tool box with many drawers that weighed around 900 pounds (Tr. p. 17). This toolbox was 7 feet long, 4 ½ feet high, 2 feet wide, and was on wheels as he had to push it from one end of the plant to the other every shift to work on the machines (Tr. p. 17).

Every time he worked on a machine he was required to get inside a machine (Tr. p. 18). This required him to stand, squat, and get into odd angles (Tr. p. 19). He was required to stand for long periods of time, basically the whole shift unless he had to lie on his back underneath a machine to work on it (Tr. p. 19). Almost all the work he did required him to have either his arms out in front of him, or up over his head (Tr. p. 19). Petitioner continued at this job until his termination by Respondent.

Prior to this injury, Petitioner suffered from migraine headaches (Tr. p. 20). He started having them in his late 20's and into his 30's (Tr. p. 20). They were not bad at first, and came and went, but then got worse in his early 40s (Tr. p. 20). He did seek medical treatment for the headaches, and treated with Dr. Mahmood and Dr. Harvey for at least a year (Tr. p. 20). His last treatment of any kind for headaches prior to his work injury was with Dr. Mahmood 13 months prior to the work injury (Tr. p. 21). In the 13 months prior to the work injury, he was not having a problem with headaches (Tr. p. 21). At the time of his last visit with Dr. Mahmood in February of 2010, Petitioner was not having headaches (Tr. p. 21). Dr. Mahmood had put him on a blood pressure medication, which took care of his migraines completely (Tr. p. 22). Petitioner reported this history to Dr. Pavinderpal Gill during the course of his treatment on December 1, 2011 (Pet. Exh. 4, p. 18). Petitioner reports having no issues with headache whatsoever in the months prior to the work injury, and Dr. Mahmood told him at their last meeting to come back if he had more problems and to keep taking the medication (Tr. p. 22). He did not see Dr. Mahmood again, and had no plans to see him at the time of the work injury (Tr. p. 22).

Prior to his work injury, Petitioner never had a history of numbness or pain in his arms or shoulders, nor any condition with his arms and shoulders while working (Tr. p. 23). He had never had medical treatment for his arms or shoulders prior to the work injury, and had never had any sort of traumatic event involving his arms, shoulders, or neck (Tr. p. 23). He never suffered from any medical condition that would cause him to lose grip strength, drop objects, or affect his ability to use his fine motor skills (Tr. pp. 23-24). Petitioner never suffered from any condition in his arms, shoulders, neck, or wrist that would prevent him from driving prior to his work injury (Tr. p. 24). He had never had problems with his neck, shoulders, or wrists to affect his ability to do things around the house, and his nothing about his neck or shoulders affected his lifestyle prior to this work injury (Tr. p. 24).

On May 29, 2011, Petitioner worked the night shift from 7:00 p.m. to 7:00 a.m., and he was injured sometime between 7:00 and 8:00 p.m. (Tr. p. 25). He had received a work order to take part of a machine apart which involved the turret on the front which makes the cup shapes on the machine, and at the time of injury, he was taking the turret off (Tr. pp. 25-26). The tabletop of the machine is at roughly waist height, and there is a set of stairs that slides out and leads to the tabletop, which is stable enough to stand and work on (Tr. p. 26). Petitioner had been standing on the tabletop for 15 to 20 minutes taking parts off of the top of the turret so he could take the turret up off the machine (Tr. p. 27). Once he removed the turret, there was a solid steel shaft

with a diameter of about ½ inch and a flat end that stuck up about a foot from the bottom of the turret (Tr. pp. 27, 31-32). Petitioner was attempting to remove a sleeve that comes off over this shaft, and leaning out over th machine when the steps slipped out from under his foot (Tr. pp. 27-28). All of Petitioner's weight came forward and the solid steel shaft went through his upper lip in the space between his nose and his mouth, going all the way through and hitting his teeth on the top (Tr. pp. 28-29). The shaft went into his mouth at least an inch or two past his teeth (Tr. p. 32). Petitioner had to hold onto his lip and push himself off of the shaft so that the shaft would pull out of his face (Tr. pp. 28-29). Petitioner's top teeth were pushed back into his mouth, and folded back at an angle (Tr. pp. 29-30).

Petitioner immediately grabbed a towel and placed it over his lip (Tr. p. 30). He went to the bathroom, where he saw he could see the hole through his lip and his teeth (Tr. p. 30). He then pushed his teeth back into place with his thumbs as much as he could (Tr. pp. 30-31). There was a lot of pain in his neck area, and felt like he had been punched in the back of the neck (Tr. p. 31). He could not close his mouth properly because of his teeth (Tr. p. 32). He then walked the length of the plant with the towel over his face and spoke with his supervisor for the night, Demitri Rezinas, who was replacing his regular supervisor, John Logue (Tr. p. 33). He also met with the maintenance head, Jim Dowdy (Tr. p. 33).

Demetri at first told Petitioner that he should just tape it shut, and that he should not go to the doctor, because if Petitioner received stitches, it would be reported as an accident which would look bad (Tr. p. 35). Eventually, Demetri drove Petitioner to the Emergency Room at Shelby Memorial Hospital (Tr. p. 36; Pet. Exh. 1). The laceration was treated in the Emergency Room, and Petitioner returned to work that night and finished out his shift (Tr. p. 37; Pet. Exh. 1).

Petitioner then saw a dentist, Dr. Brian Hastings, on March 31, 2011, who noted damage to teeth 8 and 9 (Tr. p. 37; Pet. Exh. 2). Dr. Hastings then referred Petitioner to Dr. Michael Hudson of Hudson Orthodontics in Decatur (Tr. p. 37; Pet. Exh 3). Dr. Hudson put braces on his teeth, as he was having problems closing his mouth (Tr. pp. 38-39; Pet. Exh. 3). His teeth would hit together and there was no way to close them (Tr. p. 38). The braces were not authorized for several months, and in April of 2011, Dr. Hastings put cement on his back teeth so that that would close together without damaging all of his front teeth (Tr. p. 39; Pet. Exh. 3, pp. 2-3). Dr. Hudson also noted in April that Petitioner had right and left TMJ which he described as "crunchy" (Pet. Exh. 3, p. 3). Eventually, the braces were authorized and put on in October of 2011 (Tr. p. 39; Pet. Exh. 3, p. 5).

Petitioner began getting headaches and neck pain in late April and early May, once the swelling in the back of his neck went down (Tr. pp. 39-40; Pet. Exh. 3, pp. 3-5)). He started having neck pain and that caused headaches (Tr. p. 40). The pain would go all the way from the middle of his shoulders up into both sides of his skull, and radiate from there (Tr. p. 40). These headaches were much more intense than any Petitioner had prior to his work injury (Tr. p. 40). The prior headaches had come from the front and temple area of his head, whereas the headaches following the work injury came especially from the back to the sides of the head and across the top (Tr. pp. 40-41). He tried several different pain medications, but nothing worked (Tr. p. 41). His doctor said that once the braces were on, they would see if there was anything they could do about the pain with the headaches (Tr. p. 41).

He continued to work before the braces went on (Tr. p. 41). Petitioner worked until late June or early July of 2011, but the neck pain and headaches affected his ability to work, and finally got to the point where it was too much to work through (Tr. pp. 41-42). Dr. Hudson also advised he suffered from severe TMJ, pain from the movement and misplacement of his jaw (Tr. p. 42; Pet. Exh. 3, p.3). His jaw made noise, and continues to make noise to this day (Tr. p. 42). His jaw hurts every time he eats if he opens his jaw wider than he opens it just to speak (Tr. pp. 43-43).

Petitioner then began a course of treatment with Dr. Pavinderpal Gill of Springfield Clinic on December 11, 2011(Tr. p. 43; Pet. Exh 4). Dr. Gill noted the braces, as well as Petitioner's report that the headaches went away for a time when the braces were put on, but had since returned and become debilitating (Pet. Exh. 4, p. 19). Petitioner reported that the headaches were sharp, would crescendo, and would become so strong that he would tear up, not be able to speak, and not be able to think straight (Pet. Exh. 4, p. 19). Dr. Gill also noted hearing some popping of the TMJs (Pet. Exh. 4, p. 19). X-rays of the cervical spine showed disc space narrowing at C5-C6 and at C6-C7 (Pet. Exh. 4, p. 53).

Dr. Gill informed Petitioner he obviously had some damage, but was not sure what could be done without Petitioner seeing a neurologist (Tr. p. 43). Petitioner would occasionally miss work trying to get through the headaches (Tr. p. 44). He would get so sick he had to lay in the dark with his door shut (Tr. p. 44). At this time the only relief from the pain was when he saw Dr. Hudson who would tighten his braces (Tr. p. 44).

Although there had been a time after the braces went on when Petitioner did not suffer from headaches, they eventually returned (Pet. Exh. 4, p. 13). Once Dr. Hudson removed the braces, Dr. Gill referred Petitioner to a neurologist, who did some nerve tests, and referred Petitioner to Dr. Leslie Satchivi (Tr. p. 45; Pet. Exh. 4). Dr. Satchivi saw Petitioner on November 20, 2012 (Pet. Exh. 4, p. 60). An MRI had been taken on October 11, 2012, over a year and a half after the work injury, which revealed pinching in the spinal column and disc bulges in the C5-C6 and C6-C7 area (Tr. p. 46; Pet. Exh. 4, pp. 27-28, 60-61). Dr. Satchivi recommended conservative measures, but also discussed possible cervical discectomies at the November 20, 2012, meeting (Tr. pp. 47-48; Pet. Exh. 4, p. 62). Petitioner spoke to a member of Respondent's Human Resources Department, and told them his doctor might recommend he get surgery for his neck which would have to go through workers' compensation (Tr. p. 48). Petitioner even offered to try and schedule it in the first part of 2013, so he could use his vacation time for the surgery (Tr. p. 48).

The unrebutted testimony demonstrates that Respondent was giving Petitioner problems because he was missing work due to his doctor appointments. Although the company managing the workers' compensation claim had approved his time off, Respondent's Human Resources representatives threatened to fire him for missing time from work (Tr. p. 49). When he would show his paperwork documenting his need for approved medical care, Respondent would rescind the threats (Tr. p. 49). Respondent's private health insurance was paying for his medical bills, and Respondent was paying his deductibles and co-pays (Tr. p. 49). The only medical care Respondent paid for were dental appointments with Dr. Hudson (Tr. pp. 49-50). He was never paid any TTD for his missed days of work (Tr. p. 50).

Petitioner was fired by Respondent after he had told Human Resources his doctor was recommending surgery (Tr. pp. 50-51). On that day, Respondent gave Petitioner a work order to shut down a specific machine and work on it, as there was too much movement in one of the parts (Tr. p. 51). After he shut down the machine and took it apart, he discovered the damaged part and that the housing around it had been put together improperly (Tr. pp. 51-52). They did not have the necessary repair part, and it would have to be ordered (Tr. p. 52). When he came to work the next night, the machine had not been repaired, and the work order given to him had written on it that he was the only one who was to work on the machine, and that it had to be fixed by morning (Tr. p. 52). Although Petitioner checked with other workers and went through books, he could not fix the machine until they ordered the replacement part (Tr. pp. 52-53). The next morning, he was called into an office by a supervisor and fired (Tr. p. 53). He was told he was being fired because he had broken a machine, even though he was originally assigned to the machine because it was not working properly (Tr. p. 53). From the date of his termination, his health insurance was cancelled by Respondent, and they did not pay him any TTD until April 9, 2018 (Tr. p. 53).

At the time of his termination, he was suffering from pain (Tr. p. 54). Although it would get worse, at the time he was going back and forth between being able to work through it and finding it very difficult to work

through it (Tr. p. 54). He was also beginning to have problems with numbness in his arms and legs, which really began giving him problems in March or April of 2013 (Tr. p. 54). His arms would go numb from his shoulder to his fingertips, and his legs would go numb on one side down to mid-thigh, and from his hip to his toes on the other side to the point where he could not feel anything at all (Tr. p. 54). He had never had problems with his legs prior to this work injury (Tr. p. 55).

Following his termination, there is a gap in Petitioner's medical treatment until September of 2014 (Tr. p. 55). Petitioner had no insurance and could not afford to see a doctor (Tr. p. 55). The neck pain got continually worse, which would bring on the headaches which were worse (Tr. p. 55). The numbness in his arms and legs also continued (Tr. pp. 55-56). When this happened, he would have to sit quietly for 15 to 20 minutes before it would go away (Tr. p. 56).

Petitioner had his first Section 12 examination at the Respondent's insistence on November 19, 2013, at Arnold Dental (Tr. p. 56). Respondent did not pay for Petitioner's medical care following this exam (Tr. p. 57). Petitioner was not able to seek medical care again until he qualified for Medicare, and they began to pay for his medical expenses (Tr. pp. 57-58). This allowed Petitioner to see Dr. Satchivi again on September 23, 2014 (Tr. p. 58; Pet. Exh. 4, p. 79).

Within a month of resuming treatment, Dr. Satchivi performed a fusion surgery over two levels, C-5 to C-7, on October 13, 2014 (Tr. pp. 58-59; Pet. Exh. 4, p. 76). Following the surgery, Petitioner was without pain for 2 weeks (Tr. p. 59). Prior to the surgery, he could barely turn his neck and he had much better movement of the neck following surgery (Tr. p. 59). There was also no grinding sound in his neck following surgery (Tr. p. 59). Within a couple of weeks of the surgery, the numbness, and the pain in his neck which caused headaches, returned (Tr. p. 60). The leg numbness did get better, and was gone within 6 months (Tr. p. 67). He continued to see Dr. Satchivi for follow-up appointments periodically, but was told the numbness was probably from nerve damage, and he would have to see if the nerves were going to heal themselves (Tr. pp. 60-61).

In September of 2017, Petitioner went for a second Section 12 exam at Respondent's request, and this exam was with Dr. Brandon Larkin in St. Louis (Tr. p. 60). Dr. Larkin was not one of Petitioner's treating physicians, and Petitioner did not pay the doctor for the examination; Respondent paid for this exam (Tr. pp. 61-62). Dr. Larkin's Report, dated September 5, 2017, was entered into evidence (Pet. Exh. 12), as was Dr. Larkin's deposition, which was taken on April 19, 2018 (Pet. Exh. 13). The Report was also an Exhibit attached to the deposition (Pet. Exh. 13).

Dr. Larkin's testimony in his deposition mirrored his report. In fact, he testified that his testimony would be the same as contained in his report, including questions about subjective complaints, findings, diagnoses, and opinions (Pet. Ext. 13, pp. 3-4). He also testified that all his opinions were given within a reasonable degree of medical certainty (Pet. Exh. 13, p. 10). He further testified that he had been retained by the Respondent, that the Respondent had paid for his time, and that the Respondent had provided him with all relevant medical records (Pet. Exh. 10, pp. 14-16). The doctor further testified that he believed Mr. Rhoades was honest with him, and gave maximum effort during his exam (Pet. Exh. 13, p. 18).

Dr. Larkin's Section 12 examination of the cervical spine revealed an objective finding of "tenderness to palpation at C4-5," as well as tissue texture changes and palpable spasm (Pet. Exh. 13, p. 18, Pet. Exh. 12, p. 10). The doctor noted that, while Petitioner's cervical spine range of motion was at a hundred percent of expected flexion, Petitioner was only at 75 percent of expected extension, 75 percent of lateral rotation bilaterally, and 75 percent of lateral flexion (Pet. Exh. p. 18; Pet. Exh. 12, p. 10). He further noted that Petitioner had a previous history of migraine headaches, but also noted these headaches had been "under control" prior to the injury, and that Petitioner had not had headaches for at least a year prior to the work injury in 2011 (Pet. Exh. 13, p. 20; Pet. Exh. 12, p. 11).

The doctor testified that it was his opinion that Petitioner sustained an injury to his head and neck on March 29, 2011, during his work activities (Pet. Exh. 13, p. 20; Pet. Exh. 12, p. 11). He further opined that this work injury resulted in an activation of Petitioner's existing degenerative joint disease, and also resulted in bilateral radiculopathy, dental injury requiring orthodontics, and a laceration to the face (Pet. Exh. 13, p. 21, Pet. Exh. 12, p. 11).

Doctor Larkin testified that Petitioner suffers from two specific conditions (Pet. Exh. 13, p. 21; Pet. Exh. 12, p. 11). The first is bilateral upper extremity numbness which is likely secondary to cervical nerve root injury (Pet. Exh. 13, p. 21; Pet. Exh. 12, p. 11). Due to this condition, Petitioner has a moderate severity disability which manifests itself in that Petitioner has "significant difficulty with any activities that require him to lift his arms, hold or carry objects, or drive longer than a few minutes" (Pet. Exh. 13, pp. 20-21; Pet. Exh. 12, p. 11). The second condition is "intractable headaches, posttraumatic in nature, which have been diagnosed as cluster migraine headaches and/or migraine headaches," and that he also seems to be suffering from a "bilateral 3rd occipital neuralgia," which was evident from the provocation of his symptoms with deep palpation of those two nerves (Pet. Exh. 12, p. 11). Due to this condition, Petitioner "is suffering from a mild disability on most days occasionally progressing to a moderate to severe disability when his symptoms increase substantially" (Pet. Exh. 13, p. 22; Pet. Exh. 12, p. 11).

With regard to the upper extremity numbness, Dr. Larkin opined that the condition is permanent, based on the fact that none of the previous treatments had helped (Pet. Exh. 13, p. 22). His use of the term "disabilities" means that Petitioner is restricted in his ability to function, and these disabilities will prevent him from working as a maintenance mechanic in a factor (Pet. Exh. 13, p. 23). It would also affect his ability to work on machinery, lift heavy objects, use tools, wrenches, and power equipment, and do other types of similar work (Pet. Exh. 13, p. 23). Although Petitioner could perform desk work, typing, and other types of jobs that do not require a lot of lifting and movement, he would have trouble with physical labor activities (Pet. Exh. 13, p. 23).

In regards to a causal relationship, Dr. Larkin testified, to a reasonable degree of medical certainty, "The work accident of March 29 of 2011 in which he sustained injuries to his neck, head, and teeth, were the primary factor causing the resulting medical condition and disability" (Pet. Exh. 13, p. 24; Pet. Exh. 12, p. 11). In relation to any claim that degenerative changes were responsible for Petitioner's condition, Dr. Larking testified, "While the degenerative changes are noted, the injury sustained at work seemed to activate pain and numbness that had previously not been present" (Pet. Exh. 13, p. 24; Pet. Exh. 12, p. 12). The doctor opined that, in regards to apportionment for the upper extremity numbness, two-thirds of that condition was due to the work injury, and one-third of the condition was caused by degenerative changes (Pet. Exh. 12, p. 12). In regards to the daily headaches, Dr. Larkin stated that "the work injury is 100% the prevailing factor in regards to his disability" (Pet. Exh. 12, p. 12).

Dr. Larkin recommended further nerve block injections into the suboccipital region for the headaches (Pet. Exh. 13, p. 25; Pet. Exh. 12, p. 12). He further noted that Petitioner was not at MMI (Pet. Exh. 13, p. 25).

Following Dr. Larkin's deposition, Respondent began paying TTD to Petitioner again, and such payments were made retroactive to the deposition date, April 19, 2018 (Tr. p. 63). The TTD payments did not go back to the date of Dr. Larkin's report, September 5, 2017, which was about 7 months before the deposition (Tr. pp. 63-64). TTD was paid by Respondent to Petitioner until he was placed at MMI following his third Section 12 exam, performed by Dr. Russell Cantrell, on July 22, 2019 (Tr. p. 64).

Dr. Larkin's report recommended that Petitioner have follow-up treatment, and Respondent paid for Petitioner to have 2 visits with Dr. Robert Hagan, a doctor with the Neuropax Clinic of St. Louis, to have the

type of nerve block injections Dr. Larkin recommended (Tr. p. 65). Petitioner saw Dr. Hagan in October and November of 2018, and Dr. Hagan gave him shots in the back of his neck and base of his skull (Tr. p. 65). The shots received during the first visit seemed to help a bit when he got them, but by the time he got home the pain was worse than it had been before (Tr. p. 66). He called Dr. Hagan's office to describe it to him that day (Tr. p. 66). When he went for the second visit, he thought he would receive more treatment, but they just told Petitioner there was nothing more they could do for him (Tr. p. 66).

On July 22, 2019, Petitioner submitted to his third Section 12 exam request from Respondent, this one by Dr. Russell Cantrell of St. Louis (Resp. Exh. 1, p. 10). Dr. Cantrell is a physician board certified in physical medicine and rehabilitation, but is not a neurologist, nor a treating physician of the Petitioner (Resp. Exh. 1, p. 36). His physical examination was performed over 8 years after Petitioner's injury, and lasted "at most ten minutes" (Resp. Exh. 1, pp. 36-40). His cranial tests consisted entirely of 3 tests in which the patient follows his fingers around (Resp. Exh. 1, pp. 41-43). The doctor also admitted that Respondent failed to provide him with records from Dr. Mahmood, Dr. Dycoco, Dr. Quizon, or Dr. Harvey (Resp. Exh. 1, pp. 45-46, 48, 58-59). He testified that Petitioner gave full effort during his examination, and that during the exam, there was still limitation in range of motion and tenderness to palpation in the right scalene musculature, even though it was more than 8 years since the injury (Resp. Exh. 1, pp. 43-44). Dr. Cantrell also admitted on cross examination that, although he testified in his direct examination that Petitioner told him he "had not had any migraine headaches for about two years before his work injury in 2011," what Petitioner had actually told him was that he had not had any migraine headaches "in the one or two years" prior to the work injury (Resp. Exh. 1, pp. 10-11, 43-44, 78). He received all of the records he reviewed from the Respondent, and has no evidence of Petitioner receiving any treatment for headaches in the 13 months prior to his work injury (Resp. Exh. 1, pp. 45-46). He has no opinion to offer on the issue of causation, and he cannot disagree with Dr. Larkin's opinion that the work injury resulted in an activation of his existing degenerative joint condition (Resp. Exh. 1, pp. 52, 56), and does not disagree with Dr. Larkin's diagnoses that Petitioner sustained bilateral radiculopathy, a dental injury requiring orthodontics, and a laceration to the face as a result of the work injury (Resp. Exh. 1, p. 48, 51-52). He cannot disagree with Dr. Larkin's conclusion that Petitioner suffered bilateral upper extremity numbness as a result of this work injury (Resp. Exh. 1, pp. 53-54). He did place Petitioner at MMI, as of July 22, 2019 (Resp. Exh. 1, p. 27).

Today, Petitioner continues to suffer from neck pain (Tr. pp. 66-67). He has headaches every day (Tr. p. 67). He continues to have arm and hand numbness (Tr. p. 67). Whenever Petitioner does anything with his arms in front of him, it causes the numbness in his arms (Tr. p. 67). Any activity in which he has his hands in front of him, including driving a car, pushing a lawn mower, riding his other lawn mower, preparing food, or working at his computer will cause complete numbness from his shoulder to his fingertips after 10 to 15 minutes of activity (Tr. pp. 67-68). He can move his arms and hands, but he cannot feel them, or feel anything touching him there (Tr. p. 68). He has hurt his hands at different times because he was holding onto a glass so hard, and not wanting to drop it, that he broke the glass and cut his hand (Tr. p. 68). If he mows the lawn, he must stop after 15 minutes because he cannot feel his arms, and simply relax until the feeling comes back (Tr. p. 68). He can only drive short distances for short periods of time, and his daughter drives him most of the time (Tr. p. 70). Sometimes, his 80 year old mother has to drive him to his doctor appointments when his daughter cannot get off work (Tr. p. 70). The only thing that helps when things go numb is to stop moving, sit, and relax his shoulders (Tr. p. 112). He did apply for a few jobs after his termination in 2012 or 2013 because he wanted to work, but he was not able to find a job after being honest about his physical condition (Tr. p. 86).

If Petitioner holds out his arms for about 10 minutes, they will go numb (Tr. p. 70). He does not see how he could get a job in his current physical condition (Tr. pp. 70-71). He cannot hold hand tools for more than 10 minutes (Tr. p. 71). He cannot do any of the fine hand/eye coordination work that he was doing for Respondent for any amount of time that would let him perform work (Tr. p. 71). He cannot perform a physical labor job, and lacks the education, training, and job experience necessary to have a desk job (Tr. p. 71). He

cannot even do computer work for more than 10 minutes without his arms going numb (Tr. pp. 71-72). His balance has been affected and he gets dizzy (Tr. p. 72). Some days, the pain will make him feel sick, and he cannot be out in the sunlight (Tr. p. 72). The pain is in his neck shoots through his head everyday (Tr. p. 72). The pain will increase, then plateau for a while, and then get worse again (Tr. pp. 72-73). He has tried medications for migraines and cluster headaches, but has had problems with side effects (Tr. p. 74). Today, he does not take medication for the pain, as the last neurologist he saw said he had gone through all suggested medications but morphine, and Petitioner does not want to risk getting addicted to that (Tr. pp. 74-75).

DEPOSITION OBJECTIONS

Section 12 of the Illinois Workers' Compensation Act provides that an examining doctor engaged by either the employer or the employee must deliver, either in person or by registered mail, a copy of his or her written report to the other party or a representative as soon as practical, but not later than 48 hours before the time the case is set for hearing. 820 ILCS 305/12. This rule applies to examining physicians, as well as treating physicians. *Mulligan v. Illinois Workers' Compensation Comm'n*, 408 Ill. App.3d 205, 946 N.E.2d 421 (1st Dist. 2011). In this case, the deposition of Respondent's Section 12 examining witness, Dr. Russell Cantrell, was taken on February 6, 2020 (Resp. Exh. 1). The Report of Dr. Cantrell was made part this deposition (Resp. Exh. 1).

Dr. Cantrell's report was delivered to counsel for the Petitioner more than 48 hours prior to Dr. Cantrell's deposition. However, an attempt was made to elicit several opinions from Dr. Cantrell during the deposition that were not disclosed in writing by Respondent more than 48 hours prior to the deposition, nor is there any evidence that such written opinions were disclosed to Petitioner within 48 hours of the final hearing in this Cause. Counsel for Petitioner objected to these opinions during Dr. Cantrell's deposition.

Therefore such opinions should be stricken from Dr. Cantrell's deposition, and from the record of proceedings, and the Arbitrator has given them no consideration. Specifically, testimony that begins on line 11 of page 14 of such Exhibit, through line 3 of page 15, is hereby stricken. Also, the testimony from line 20 on page 18 through line 17 on page 19 of such Exhibit is stricken. In addition, the testimony from line 10 on page 23 through line 2 on page 24 of such Exhibit is stricken.

DISPUTED ISSUES

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

The evidence demonstrates that Respondent's current condition of severe neck pain causing intractable headaches, as well as consistent arm numbness was causally related to his work injury of March 29, 2011. The testimony and medical records show that Petitioner has been consistent in his testimony and in his reports to his medical providers. The Section 12 Examiners retained by Respondent have both stated they believed Petitioner to have been honest and to have given maximum effort during their respective examinations (Pet. Exh. 13, p. 18; Resp. Exh. 1, pp. 43-44). Petitioner was also credible in his testimony, despite the fact that almost 8 ½ years have elapsed since the date of injury.

The evidence demonstrates that On May 29, 2011, Petitioner was injured within the course and scope of his employment with Respondent while working on a piece of machinery at Respondent's plant in Shelbyville, Illinois. Petitioner was on a platform leaning over the machine, when the steps leading to the platform slipped out from under him (Tr. pp. 27-28). All of Petitioner's weight came forward and the solid steel shaft went

through his upper lip in the space between his nose and his mouth, going all the way through and hitting his teeth on the top (Tr. pp. 28-29). The shaft went into his mouth at least an inch or two past his teeth, pushing his top teeth back into his mouth folded back at an angel, and requiring Petitioner had to hold onto his lip and push himself off of the shaft so that the shaft would pull out of his face (Tr. pp. 28-32).

The evidence further reveals that, as a result of this work injury, Petitioner sought treatment for the facial laceration from the Emergency Department at Shelby Memorial on the day of the injury before returning to work (Tr. p. 36; Pet. Exh 1). Petitioner then treated with dentists Brian Hastings and Michael Hudson, for damage to his teeth, and for TMJ (Tr. p. 37-39; Pet. Exh. 2; Pet. Exh 3). Dr. Hudson first treated Petitioner with cement on his back teeth so that they would close together, and put braces on Petitioner's teeth (Tr. pp. 38-39; Pet. Exh. 3, pp. 2-5).

Petitioner began getting headaches and neck pain in the weeks following the injury (Tr. pp. 39-40; Pet. Exh. 3, pp. 3-5). He started having neck pain and that caused headaches (Tr. p. 40). The pain would go all the way from the middle of his shoulders up into both sides of his skull, and radiate from there (Tr. p. 40).

Petitioner was also straightforward in his testimony that, prior to this work injury, he suffered from migraine headaches (Tr. p. 20). He started having them in his late 20's at various time, and did seek treatment for migraines at various times through the years, including treatment with Dr. Mahmood and Dr. Harvey for at least a year (Tr. p. 20). His last treatment of any kind for headaches prior to his work injury was 13 months prior to the work injury (Tr. p. 21). In the 13 months prior to the work injury, he was not having a problem with headaches as Dr. Mahmood had put him on a blood pressure medication, which took care of his migraines completely (Tr. pp. 21-22), a history that he repeated to Dr. Gill during the course of his treatment on December 1, 2011 (Pet. Exh. 4, p. 18). Petitioner reported having no issues with headache whatsoever in the months prior to the work injury, and Dr. Mahmood told him at their last meeting to come back if he had more problems and to keep taking the medication (Tr. p. 22). He did not see Dr. Mahmood again, and had no plans to see him at the time of the work injury (Tr. p. 22).

The testimony from Petitioner that the headaches he suffered following the work injury were different than the headaches he had previously suffered was also credible. The headaches following the work injury were much more intense than any Petitioner had prior to his work injury; as the prior headaches came from the front and temple area of his head, whereas the headaches following the work injury came especially from the back to the sides of the head and across the top (Tr. pp. 40-41). He tried several different pain medications, but nothing worked (Tr. p. 41).

Petitioner also suffered from numbness in his arms and legs as a result of this work injury (Tr. p. 54). His arms would go numb from his shoulder to his fingertips, and his legs would go numb on one side down to mid-thigh, and from his hip to his toes on the other side to the point where he could not feel anything at all (Tr. p. 54). Prior to his work injury, Petitioner never had a history of numbness or pain in his arms or shoulders, nor had he suffered any injury to his arms and shoulders, or suffered from any condition affecting his arms and shoulders (Tr. p. 23). He had never had medical treatment for his arms or shoulders prior to the work injury, and had never had any sort of traumatic event involving his arms, shoulders, or neck (Tr. pp. 23-24). Similarly, he had never had problems with his legs prior to this work injury (Tr. p. 55).

The work injury also resulted in Dr. Satchivi performing a fusion surgery over two levels, C-5 to C-7, on October 13, 2014 (Tr. pp. 58-59; Pet. Exh. 4, p. 76). Although Petitioner had better movement in his neck following the surgery, and the leg numbness went away within 6 months, the pain in his neck, the headaches, and the numbness in his arms, returned within a few weeks (Tr. pp. 59, 60, 67).

Petitioner also had 2 visits with Dr. Robert Hagan to have the type of nerve block injections Dr. Larkin recommended (Tr. p. 65). Petitioner saw Dr. Hagan in October and November of 2018, and Dr. Hagan gave him shots in the back of his neck and base of his skull (Tr. p. 65). The shots were received during the first visit, and although they seemed to help a bit when he got them, they quickly wore off (Tr. p. 66). He did not receive any treatment during his second visit (Tr. p. 66).

The unrebutted evidence is that all of the conditions Petitioner has suffered from are causally related to the work injury of March 29, 2011. The most straightforward evidence on causation comes from Respondent's own Section 12 Examiner, Dr. Brandon Larkin, who testified that Petitioner suffers from two conditions. The first is bilateral upper extremity numbness which is likely secondary to cervical nerve root injury (Pet. Exh. 13, p. 21; Pet. Exh. 12, p. 11). The second condition is "intractable headaches, posttraumatic in nature, which have been diagnosed as cluster migraine headaches and/or migraine headaches," and that he also seems to be suffering from a "bilateral 3rd occipital neuralgia," which was evident from the provocation of his symptoms with deep palpation of those two nerves (Pet. Exh. 12, p. 11).

In regards to a causal relationship, Dr. Larkin testified, to a reasonable degree of medical certainty, "The work accident of March 29 of 2011 in which he sustained injuries to his neck, head, and teeth, were the primary factor causing the resulting medical condition and disability" (Pet. Exh. 13, p. 24; Pet. Exh. 12, p. 11). In relation to any claim that degenerative changes were responsible for Petitioner's condition, Dr. Larking testified, "While the degenerative changes are noted, the injury sustained at work seemed to activate pain and numbness that had previously not been present" (Pet. Exh. 13, p. 24; Pet. Exh. 12, p. 12). The doctor opined that, in regards to apportionment for the upper extremity numbness, two-thirds of that condition was due to the work injury, and one-third of the condition was caused by degenerative changes (Pet. Exh. 12, p. 12). In regards to the daily headaches, Dr. Larkin stated that "the work injury is 100% the prevailing factor in regards to his disability" (Pet. Exh. 12, p. 12).

No evidence was offered to challenge Dr. Larkin's conclusions on the question of causation. Respondent's other Section 12 Examiner, Dr. Russell Cantrell, specifically stated on more than one occasion that he had no opinions on the issue of causation (Resp. Exh. 1, pp. 52, 56).

The credible and unrebutted evidence shows that Petitioner's current condition was caused by his work injury of March 29, 2011.

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 consistent and credible medical evidence presented by Petitioner and his treating physicians, and the unrebutted testimony of Dr. Larkin regarding the issue of causation noted above, the medical treatment provided to Petitioner for his work injury from the date of injury on March 29, 2011, until he was placed at MMI on July 22, 2019, was all reasonable and medically necessary.

The unrebutted evidence also shows that Respondent has not paid all appropriate charges for such reasonable and necessary medical services. Petitioner testified that either he, or his health insurance that was provided by Respondent while he was an employee, paid for all of his medical care through the date of his termination, except for the medical bills of Dr. Hudson (Tr. pp. 49-50). Following his termination, Petitioner's health insurance was cancelled and no further payments were made to providers, except for the treatment provided by Dr. Hagan (Tr. pp. 53, 66). Once Petitioner qualified for Medicaid, that organization paid his medical bills (Pet. Exh. 14).

As such, Respondent shall be solely responsible for all reasonable and related medical bills associated with Petitioner's medical care related to his work injury for the time period of March 29, 2011, through July 22, 2019, including, but not limited to, reimbursement to Medicaid and any third-party health insurance provider who has already paid amounts on such expenses. Respondent shall pay any remaining medical expenses which are still outstanding for such related medical.

K. TTD Benefits

Section 8(b) of the Act provides that an employee that suffers from temporary total incapacity for more than 3 days is entitled to compensation at a rate of 66 2/3% of his Average Weekly Wage, and shall continue so long as the total temporary incapacity lasts. 820 ILCS 305/8(b). Petitioner was terminated from his position on November 11, 2012 (Tr. p. 78), when he had an Average Weekly Wage of $864.40 (Tr. p. 9). He was placed at MMI on July 22, 2019 (Resp. Exh. 1, p. 27).

The testimony at hearing was that Petitioner was terminated on November 11, 2012 (Tr. p. 78). He was allegedly terminated for breaking a machine he was assigned to repair (Tr. p. 78). Respondent will note that at the time of his termination, Petitioner was not under any work restriction, and not prevented from working. However, Petitioner testified that he had been missing days off from work prior to his termination. Moreover, Petitioner clearly was not at MMI at the time of his termination. Dr. Satchivi saw Petitioner on November 20, 2012, and indicated that fusion surgery was a distinct possibility (Pet. Exh. 4, p. 60). Dr. Larkin testified that Petitioner was not at MMI as of September 5, 2017.

Petitioner testified that this occurred after Dr. Satchivi informed him that a surgery was possible. However, Petitioner was seen by Dr. Satchivi on November 20, 2012 (Pet. Exh. 4, p. 60). It is more probable that information regarding the possibility of surgery was given to Petitioner by another medical treater, and after more than 8 years, Petitioner has forgotten which provider discussed the possibility of surgery.

Following his termination, Petitioner was not paid any TTD until after Dr. Larkin's deposition on April 19, 2018, and was backdated to that date. TTD was paid by the Respondent until Petitioner was placed at MMI on July 22, 2019. It should be noted that, although Dr. Larkin issued his report stating that Petitioner was not at MMI on September 5, 2017, Respondent only paid TTD retroactive to April 19, 2018, the date of Dr. Larkin's deposition. If Respondent claims that it paid TTD once it became aware there was a medical opinion stating that Petitioner was not at MMI, it should have made such payments, at the earliest, retroactive to September 5, 2017, the date of the report prepared by its own Section 12 Examiner.

However, Petitioner was entitled to TTD from the date of his termination on November 11, 2012. "It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.* whether the claimant has reached maximum medical improvement." *Interstate Scaffolding Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill.2d 132, 142, 923 N.E.2d 266, 271 (2010). Looking to the Act, there is no reasonable construction of its provisions which supports a finding that TTD benefits may be denied an employee who remains injured, yet has been discharged by his employer for "volitional conduct " unrelated to his injury. *Id.* at 146, 923 N.E.2d at 274. A thorough review of the Act shows it contains no provision for the denial, suspension, or termination of TTD benefits as a result of an employee's discharge by the employer. *Id.* Nor does the Act condition TTD benefits on whether there has been "cause" for the employee's dismissal. *Id.*

The ruling of *Interstate Scaffolding* is clear, termination of the employee is not a basis for the termination of temporary benefits. On November 11, 2012, Petitioner had not been placed at MMI. Therefore,

Respondent had the option of employing him pursuant to whatever restrictions his treating physicians had placed on him, or paying him TTD. Respondent chose to do neither. Since it did not employ or pay Petitioner after November 11, 2012, it was responsible for paying him TTD until he reached MMI.

Therefore Petitioner is entitled to TTD payments from November 11, 2012, until TTD payments were started on April 19, 2018, a period of a period of 283 3/7 weeks. As Petitioner's Average Weekly Wage was $864.40, he was entitled to weekly payments of 66 2/3% of this amount, or $576.27, for this period. Therefore, Respondent owed Petitioner Temporary total Disability payments in the total amount of $163,331.38.

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

Petitioner has proven that he sustained a permanent partial disability as a result of this work injury, consisting of severe neck pain causing intractable headaches, as well as consistent arm numbness. The medical evidence reveals that, although Petitioner may no longer be working for Respondent, he continues to suffer from serious and permanent restrictions.

Petitioner testified as to the affects his work injury has had on his life. He continues to suffer from neck pain (Tr. pp. 66-67). He has headaches every day, and continues to have arm and hand numbness (Tr. p. 67). Whenever Petitioner does anything with his arms in front of him, it causes the numbness in his arms (Tr. p. 67). Any activity in which he has his hands in front of him, including driving a car, pushing a lawn mower, riding his other lawn mower, preparing food, or working at his computer will cause complete numbness from his shoulder to his fingertips after 10 to 15 minutes of activity (Tr. pp. 67-68). He can move his arms and hands, but he cannot feel them, or feel anything touching him there (Tr. p. 68). He has hurt his hands at different times because he was holding onto a glass so hard, and not wanting to drop it, that he broke the glass and cut his hand (Tr. p. 68). If he mows the lawn, he must stop after 15 minutes because he cannot feel his arms, and simply relax until the feeling comes back (Tr. p. 68). He can only drive short distances for short periods of time, and his daughter drives him most of the time (Tr. p. 70). Sometimes, his 80 year old mother has to drive him to his doctor appointments when his daughter cannot get off work (Tr. p. 70). The only thing that helps when things go numb is to stop moving, sit, and relax his shoulders (Tr. p. 112).

If Petitioner holds out his arms for about 10 minutes, they will go numb (Tr. p. 70). He does not believe he can get a job in his current physical condition (Tr. pp. 70-71). He cannot hold hand tools for more than 10 minutes (Tr. p. 71). He cannot do any of the fine hand/eye coordination work that he was doing for Respondent for any amount of time that would let him perform work (Tr. p. 71). He cannot perform a physical labor job, and cannot do computer work for more than 10 minutes without his arms going numb (Tr. pp. 71-72). His balance has been affected and he gets dizzy (Tr. p. 72). Some days, the pain will make him feel sick, and he cannot be out in the sunlight (Tr. p. 72). The pain is in his neck shoots through his head everyday (Tr. p. 72). The pain will increase, then plateau for a while, and then get worse again (Tr. pp. 72-73). He has tried medications for migraines and cluster headaches, but has had problems with side effects, and he does not take medication for the pain (Tr. pp. 74-75).

According to Section 8.1(b) of the Illinois Workers' Compensation Act, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

1. The reported level of impairment pursuant to the AMA Guidelines;
2. The occupation of the injured employee;
3. The age of the employee at the time of the injury;
4. The employee's future earning capacity; and
5. Evidence of disability corroborated by the treating medical records.

820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. Id. As there was no AMA impairment report made in this case, only factors 2 through 5 should be considered.

The occupation of the injured employee is an important factor. Here, the evidence shows both the physical requirements of a mechanic at Respondent's facility, and the delicate nature that is sometimes required to perform that work. The machines Petitioner worked on are very large and are spaced over an area 3 blocks long (Tr. p. 13-14). His job required detailed hand/eye coordination, as each machine had thousands of moving parts, which had to be taken apart and reassembled in exactly the right way (Tr. p. 15). These machine parts varied in size from 150 pound turrets to stamp-sized pieces of metal that had to fit together perfectly with screws, and he was required to handle them all (Tr. pp. 15-16). His work involved the repeated twisting of the wrist, as he needed to use both big and small hand tools, which were kept in a multi-leveled tool box with many drawers that weighed around 900 pounds (Tr. p. 17). This toolbox was very large and on wheels, and he had to push it from one end of the plant to the other every shift to work on the machines (Tr. p. 17). He was required to stand, squat, and get into odd angles to work inside these machines (Tr. p. 19). He was required to stand for long periods of time, or lie on his back underneath a machine to work on it (Tr. p. 19). Almost all the work he did required him to have either his arms out in front of him, or up over his head (Tr. p. 19).

The evidence shows that Petitioner has an extremely physical job with a lot of lifting and working with large tools, as well as the requirement of pushing a 900 pound tool box all around a 3 block long facility. The job also required Petitioner to be able to work in small and confined spaces, and to work at odd angles. But the job also required him to be able to use hand/eye coordination, and do the delicate work required to repair and maintain very small parts that had to be assembled correctly. The conditions that Petitioner suffers from as a result of his work injury – neck pain with intractable headaches, plus arms that go numb after 10 minutes of working away from his body - make it impossible for him to perform either the very physical requirements of his job, or the very delicate work the job also requires.

The next Section 8.1(b) factor to consider is Petitioner's age at the time of injury. At the time he was injured, Petitioner was 43 years old, and was 53 at the time of the final hearing. He attended college for 2 years, but illness in his family meant he could not complete his degree (Tr. p. 10). His formal job training is in running printing presses for newspapers, and working on the machines at Respondent's facility, which are very specific to that industry (Tr. pp. 10-12). He has no formal training as a mechanic (Tr. p. 12). Given the nature of Petitioner's injuries, the physical requirements of the job, and his age, Petitioner has not been able to recover to his pre-injury condition, and almost certainly never will.

The next Section 8.1(b) factor to consider is the employee's future earning capacity. As discussed above, Petitioner's ability to earn future income is greatly limited. He is now 53 years old, with a permanent condition of neck pain, intractable headaches, and arm numbness which results from use of his arms after only 10 minutes. He does not have a college degree, as he was forced to drop out of college due to family hardship (Tr. p. 10). Petitioner's has attempted to find employment with another employer since the work injury, but is not able to secure employment once he tells a potential employer about his medical condition (Tr. p. 86). Based upon Petitioner's age, education, current medical condition, and lack of employment since the work injury, Petitioner's future earning capacity is very low.

The final Section 8.1(b) factor to consider is evidence of disability corroborated by the treating medical records. As noted above, the medical records demonstrate that Petitioner suffers from severe neck pain, intractable headaches, and arm numbness which are now a permanent condition. The best evidence of ongoing disability is from Respondent's own Section 12 Examiner, Dr. Brandon Larkin, who testified that Petitioner suffers from two specific conditions (Pet. Exh. 13, p. 21; Pet. Exh. 12, p. 11). The first is bilateral upper extremity numbness which is likely secondary to cervical nerve root injury (Pet. Exh. 13, p. 21; Pet. Exh. 12, p.

11). Due to this condition, Petitioner has a moderate severity disability which manifests itself in that Petitioner has "significant difficulty with any activities that require him to lift his arms, hold or carry objects, or drive longer than a few minutes" (Pet. Exh. 13, pp. 20-21; Pet. Exh. 12, p. 11). The second condition is "intractable headaches, posttraumatic in nature, which have been diagnosed as cluster migraine headaches and/or migraine headaches," and that he also seems to be suffering from a "bilateral 3rd occipital neuralgia," which was evident from the provocation of his symptoms with deep palpation of those two nerves (Pet. Exh. 12, p. 11). Due to this condition, Petitioner "is suffering from a mild disability on most days occasionally progressing to a moderate to severe disability when his symptoms increase substantially" (Pet. Exh. 13, p. 22; Pet. Exh. 12, p. 11).

With regard to the upper extremity numbness, Dr. Larkin opined that the condition is permanent, based on the fact that none of the previous treatments had helped (Pet. Exh. 13, p. 22). His use of the term "disabilities" means that Petitioner is restricted in his ability to function, and these disabilities will prevent him from working as a maintenance mechanic in a factor (Pet. Exh. 13, p. 23). It would also affect his ability to work on machinery, lift heavy objects, use tools, wrenches, and power equipment, and do other types of similar work (Pet. Exh. 13, p. 23). Although Petitioner could perform desk work, typing, and other types of jobs that do not require a lot of lifting and movement, he would have trouble with physical labor activities (Pet. Exh. 13, p. 23).

With regard to the neck pain and headaches, Dr. Larkin did not testify that this condition was permanent, and recommended further nerve block injections into the suboccipital region for the headaches (Pet. Exh. 13, p. 25; Pet. Exh. 12, p. 12). He further noted that Petitioner was not at MMI (Pet. Exh. 13, p. 25). However, those nerve block injections were performed by Dr. Hagan, with no success (Tr. pp. 65-66). As there has been no improvement to the neck pain and headaches, and Petitioner has been placed at MMI, his condition of neck pain and intractable headaches is found to be permanent as well.

In this regard, the testimony of Dr. Larkin is much more credible than the testimony of Respondent's third Section 12 Examiner, Dr. Russell Cantrell. Dr. Cantrell testified that there are no limitations to Petitioner performing a job such as the one he held with Respondent (Pet. Exh. 1). However, such a position is belied by the Petitioner's medical records, the testimony of Dr. Larkin, and the Petitioner's own testimony, which are all found to be more credible than Dr. Cantrell's testimony.

Many factors lead to the conclusion that Dr. Cantrell's testimony is not credible. Dr. Cantrell is not a neurologist, and his physical examination of Petitioner was performed over 8 years after Petitioner's injury, lasted "at most ten minutes" (Resp. Exh. 1, pp. 36-40) and his cranial tests consisted entirely of 3 tests in which the patient follows his fingers around (Resp. Exh. 1, pp. 41-43). The doctor also admitted that Respondent had provided him with all of the medical records he had reviewed before preparing his report, and that Respondent failed to provide him with records from Dr. Mahmood, Dr. Dycoco, Dr. Quizon, or Dr. Harvey (Resp. Exh. 1, pp. 45-46, 48, 58-59). He also admitted it was important for a reviewing doctor to have all of the pertinent medical records (Pet. Exh. 1, pp. 59-60). He testified that Petitioner gave full effort during his examination, and that during the exam, there was still limitation in range of motion and tenderness to palpation in the right scalene musculature, even though it was more than 8 years since the injury (Resp. Exh. 1, pp. 43-44). Dr. Cantrell also admitted on cross examination that, although he testified in his direct examination that Petitioner told him he "had not had any migraine headaches for about two years before his work injury in 2011," what Petitioner had actually told him was that he had not had any migraine headaches "in the one or two years" prior to the work injury (Resp. Exh. 1, pp. 10-11, 43-44, 78). He also admitted there was no evidence of Petitioner receiving any treatment for headaches in the 13 months prior to his work injury (Resp. Exh. 1, pp. 45-46). He further had no opinion to offer on the issue of causation, and he testified he could not disagree with Dr. Larkin's opinion that the work injury resulted in an activation of Petitioner's existing degenerative joint condition (Resp. Exh. 1, pp. 52, 56), and did not disagree with Dr. Larkin's diagnoses that Petitioner sustained bilateral radiculopathy, a dental injury requiring orthodontics, and a laceration to the face as a result of the work injury

(Resp. Exh. 1, p. 48, 51-52). He also could not disagree with Dr. Larkin's conclusion that Petitioner suffered bilateral upper extremity numbness as a result of this work injury (Resp. Exh. 1, pp. 53-54). On the whole, Dr. Larkin offered a more thorough exam and review of the pertinent records than Dr. Cantrell, and his conclusions and opinions are more credible and more worthy of consideration.

Section 8(d)1 of the Workers' Compensation Act provides that, if after the accidental injury has been sustained, the employee becomes partially incapacity from pursuing his usual and customary line of employment, he shall receive compensation equal to 66 2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged, and the average amount he was able to earn in some suitable employment following the work injury. 820 ILCS 305/8(d)1. As Petitioner's injury occurred before September 1, 2011, the payment under this provision shall last "for the duration of his disability." 820 ILCS 305/8(d)1.

Petitioner will not be able to return to his employment with Respondent, or with any employer in which heavy physical labor is involved. His education and job experience further limits his ability to secure employment. He is therefore entitled to an award under Section 8(d) 1. At the time of his injury, Petitioner's Average Weekly Wage was $864.40. Although Respondent is severely limited in the type of work he can do, no physician has stated Petitioner is totally disabled. The minimum wage for the State of Illinois at the time Petitioner was placed at MMI was $8.25 per hour, and it is presumed Petitioner could have gotten a job earning this amount of income. This would result in an Average Weekly Wage of $330.00. The difference between the two Average Weekly Wages is $534.40, and 66 2/3% of this amount is $356.27. Therefore, Petitioner is entitled to Permanent Partial Disability payments from Respondent in the amount of $356.27 per week for the duration of his disability, retroactive to July 22, 2019.

CONCLUSION

The Arbitrator has carefully reviewed the medical records, all of the Exhibits submitted by the Petitioner and the Respondent, and has carefully observed the demeanor and credibility of the Petitioner during testimony. The Arbitrator finds that the Petitioner has met his burden of proof that a work-related accident occurred on March 29, 2011, causing Petitioner to suffer permanent injuries to his neck, intractable headaches, and arm numbness. The Arbitrator finds that Respondent shall pay for all medical services, pursuant to the Illinois medical fee schedule, associated with Petitioner's related medical treatment from March 29, 2011, through July 22, 2019, as provided in Sections 8(a) and 8.2 of the Act, and shall reimburse Medicaid and any third-party health insurance provider, for health care related costs they have paid for Petitioner's benefit during this time period. The Arbitrator finds that Petitioner is entitled to Temporary Total Disability Payments, as provided in Section 8(b) of the Act, in the amount of $576.27 per week for the time period of November 12, 2012, through April 19, 2018, a period of 283 3/7 weeks, for a total amount of $163,331.38. Petitioner is further entitled to an award of Permanent Partial Disability, as provided in Section 8(d)1 of the Act, at a rate of $356.27 per week for the duration of his disability, retroactive to July 22, 2019.

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

10/24/20
Date

OCT 26 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC024632
Case Name	BALA, EUGENIA v. COVENANT CARE AT HOME
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0428
Number of Pages of Decision	8
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Ursula Babicz
Respondent Attorney	Raymond Asher

DATE FILED: 8/23/2021

/s/ Barbara Flores, 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

EUGENIA BALA,

Petitioner,

vs. NO: 15 WC 24632

COVENANT CARE AT HOME,

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review, wherein she requests review of Arbitrator Carlson's order denying reinstatement of his case. The Commission, after considering the filings of the parties and the record, and being advised of the facts and law, affirms the Arbitrator's denial of reinstatement. The Commission's findings of fact and conclusions of law are as follows.

I. STATEMENT OF FACTS

On July 22, 2015, Petitioner filed an Application for Adjustment of Claim, alleging that "PETITIONER WAS INJURED WHILE AT WORK," specifying a back injury on June 25, 2015. On May 15, 2019, Arbitrator Carlson dismissed Petitioner's case for want of prosecution.

A. Petitioner's Motion to Reinstate

On June 14, 2019, Petitioner filed a Motion to Reinstate her case. The motion alleged that her case was dismissed in error because she never received a Notice of Motion to Dismiss filed by the Respondent. The motion also alleged that "the case has been settled months ago." The motion further alleged that Petitioner had been "waiting many months in anticipation of Respondent's Medicare set-aside pursuant to the Arbitrator's recommendation."

B. Respondent's Objections to Reinstatement

On July 3, 2019, Respondent filed its Objections to the Motion to Reinstate, setting forth

its alleged version of the chronology of events in the case as follows.

Respondent alleged that Petitioner's counsel failed to appear for trial dates on July 18, 2015, October 19, 2016, and January 18, 2017. After a pretrial conference before Arbitrator Carlson, Respondent's counsel tendered settlement contracts to Petitioner's counsel on February 15, 2017, which subsequently were amended and re-submitted to Petitioner's counsel on March 10, 2017.

Respondent also alleged that it filed a Motion to Dismiss on June 15, 2017 after failing to receive approved settlement documents. According to Respondent, following several continuances, Arbitrator Carlson set the Motion to Dismiss for hearing on August 16, 2017. Settlement documents were tendered on that date and the case was not dismissed.

Respondent further alleged that on August 25, 2017, it filed another Motion to Dismiss. Respondent claimed that Petitioner's counsel failed to appear on September 6, 2017 and September 11, 2017. Arbitrator Carlson entered a dismissal order on the latter date.

On September 28, 2017, Petitioner filed a motion to reinstate the case. On November 13, 2017, Arbitrator Carlson reinstated the case. Respondent alleged that Petitioner's counsel claimed she was unable to proceed to trial at that time due to illness.

Respondent alleged that it filed a third Motion to Dismiss on April 9, 2018, which Arbitrator Carlson denied on August 14, 2018.

According to Respondent, the case appeared on Arbitrator Carlson's January 4, 2019 docket and was set for hearing on January 17, 2019. The case was dismissed for want of prosecution on that date, allegedly because Petitioner's counsel failed to appear at the hearing.

Respondent additionally alleged that it had no notice that Petitioner filed a February 20, 2019 motion to reinstate which was granted on March 14, 2019, as it discovered from the Commission's database.

Respondent ultimately alleged that on May 3, 2019, the case was set for trial on May 15, 2019 and Arbitrator Carlson dismissed the case for want of prosecution on the latter date when Petitioner's counsel failed to appear at the hearing. Respondent added that it would be prejudiced by reinstatement because it must continue to maintain reserves, track witnesses and fund its litigation expenses.

C. Petitioner's Response to Respondent's Objections

On July 12, 2019, Petitioner filed her response to Respondent's Objections to the Motion to Reinstate. Petitioner acknowledged that on March 10, 2017, Respondent's counsel submitted a settlement contract and employment release. Petitioner also emphasized that Respondent's counsel filed a Motion to Dismiss only nine days after the August 16, 2017 pretrial conference.

Petitioner's counsel observed that Respondent's counsel did not mention that he was

dealing with an insurance adjuster who did not agree to the removal of certain language from the settlement contract. Petitioner's counsel also asserted that on November 8, 2017, she notified Respondent's counsel that the language of the settlement agreement was unacceptable and that the Arbitrator had stated during prior pretrial conferences that Respondent faced significant exposure if the case proceeded to trial, attaching an email she sent to Respondent's counsel as an exhibit. Petitioner's counsel also attached a November 10, 2017 email addressed to Arbitrator Carlson and Respondent's counsel, seeking clarification regarding language in the settlement agreement referring to applications for Medicare and SSDI. Petitioner's counsel further attached a December 18, 2017 email addressed to opposing counsel ostensibly attaching proposed changes to the settlement agreement (the email attachment is not included in Petitioner's Response).

Petitioner's counsel alleged that Respondent's counsel continued to assure her that he was working with the insurance adjuster to have the language of the settlement modified, while also filing motions to dismiss. Petitioner's counsel attached an October 4, 2018 email in which she claimed that Respondent's counsel had indicated that the insurer agreed to remove the questionable sentence from the settlement agreement. Petitioner's counsel also attached a November 8, 2018 email addressed to Respondent's counsel asking whether he was able to adjust the language of the contract. Petitioner's counsel further asserted that Respondent's counsel never removed the disputed language from the agreement although he assured her that he would, attaching a copy of the proposed settlement agreement. Petitioner's counsel further alleged that in March 2019, the Arbitrator stated that because Petitioner had reached 62 years and 6 months of age, Respondent's counsel should prepare an MSA, to which Respondent's counsel agreed but obtained a dismissal instead. Lastly, Petitioner's counsel argued that Petitioner would be prejudiced by the denial of reinstatement because Respondent had disregarded his confirmation to remove the disputed language from the settlement agreement.

D. Respondent's Reply to Petitioner's Response

On July 15, 2019, Respondent filed its Reply to Petitioner's Response to its Objections. Respondent observed that Petitioner's Motion to Reinstate stated that this case was originally dismissed on May 15, 2019, when it had been dismissed and reinstated twice previously. Respondent disputed Petitioner's claim of error based on her failure to receive a Notice of Motion to Dismiss, replying that the case was dismissed because it was "above the line and nobody appeared on [P]etitioner's behalf." Respondent also disputed Petitioner's statement that the case had been settled, asserting that the parties remained at odds over the proposed language of the contract. Respondent further addressed the emails attached as exhibits to Petitioner's Response, arguing that the continuing dispute over the language of the proposed settlement agreement did not absolve Petitioner's counsel from having to appear before the Arbitrator when the case was assigned for hearing. Lastly, Respondent asserted that the prior dismissals and reinstatements had prejudiced Respondent's ability to defend the case.

E. Hearing on the Motion to Reinstate

On July 16, 2019, Petitioner's Motion to Reinstate was heard by Arbitrator Carlson. During the hearing, Petitioner's counsel asserted that for some unknown reason, the case

appeared on the May 3, 2019 status call and was set for trial on May 15, 2019. Tr. 4. Petitioner's counsel stated that she was unaware of the May date because the case had been on the January status call and was not dismissed until March. Tr. 4. Petitioner's counsel inferred that the case should have been set for status in April (if measured from January) or June (if measured from March). Tr. 4. She claimed that she attempted to speak to James Gentry, who was unavailable, and spoke to an unnamed clerk responsible for sending notices, but did not relate any contents of that alleged discussion. Tr. 5.

Respondent's counsel interjected that by May 3, 2019, the case was "way above the line" and the only way such a case gets set for trial is if Petitioner calls out a trial date. Tr. 6. Respondent's counsel acknowledged that his firm probably had someone at the May 3, 2019 status call, but they would not have called out a trial date without Petitioner calling out a trial date. Tr. 6. Respondent's counsel argued that Petitioner's counsel must have been aware of the May 15, 2019 trial date. Petitioner's counsel responded that she would have to check with her clerk, but that the matter did not appear on the calendar. Tr. 6.

Petitioner's counsel requested a continuance to retrieve email correspondence with opposing counsel, but there was no discussion of this request at that moment. Tr. 7.

Petitioner's counsel observed that following pretrial conferences, Respondent's counsel offered a settlement agreement including language forbidding the Petitioner to apply for disability or Social Security. Tr. 8. Petitioner's counsel maintained that it was her client's right to apply for such benefits and that the language was unenforceable and thus unlikely to be approved. Tr. 8. Petitioner's counsel referred to her November 10, 2017 email addressed to the Arbitrator and claimed that at a subsequent hearing, the Arbitrator indicated that it would be an unenforceable contract and recommended removing the disputed language. Tr. 10-11. The Arbitrator interjected that he did not recall saying that the language was unenforceable. Tr. 12. Petitioner's counsel responded that her notes indicated that the contract would not be approved. Tr. 12.

Petitioner's counsel next discussed the October and November 2018 emails addressed to Respondent's counsel regarding the status of the contract. Tr. 12-13. The Arbitrator inquired whether Respondent's counsel replied to these emails. Tr. 13-14. Petitioner's counsel answered that she had requested a continuance because she had emails but did not recall whether there was a response. Tr. 13-14. Petitioner's counsel stated that she sought to provide an email indicating that the Arbitrator had recommended that the disputed language be removed from the proposed settlement agreement. Tr. 19.

The Arbitrator requested that Petitioner's counsel address what happened on May 3, 2019 and her failure to appear on May 15, 2019. Tr. 19. Petitioner's counsel replied that she wanted to discuss the substance of the case because it was more important than the mistake that was made by the Commission in scheduling the case for May 2019. Tr. 20. Respondent's counsel stated that they were not there to discuss the substance of the case. Tr. 20. Petitioner's counsel again disagreed and asserted that there was an agreement on the substance of the contract and that the Arbitrator had directed that the disputed language be removed and an MSA be prepared. Tr. 20. Petitioner's counsel also asserted her client's right to apply for Social Security or

disability. Tr. 21. Petitioner's counsel added that the last time the parties were before the Arbitrator, Respondent's counsel had indicated that he would work on the MSA, but the case was dismissed instead. Tr. 22.

Regarding the May 15, 2019 hearing date, Petitioner's counsel again stated that she would have to check the calendar, but it appeared there was no notification. She stated that the case jumped from January until May and that the Commission did not know what happened. She requested additional time to check on her office computer and check with her clerk. Tr. 22-23. Petitioner's counsel concluded that she had exercised diligence on behalf of her client and that Respondent was not prejudiced in any matter. Tr. 23.

Respondent's counsel asserted that given the protracted dispute regarding the terms of a proposed agreement, it was clear that the case was not going to settle. Tr. 24. He reiterated that the ongoing dispute did not excuse Petitioner's counsel from appearing before the Arbitrator. Tr. 25. He also reiterated that someone from Petitioner's counsel's office had to have appeared on May 3, 2019 because the case was set for trial. Tr. 25. The Arbitrator inquired about the March 14, 2019 reinstatement. Tr. 26. Respondent's counsel claimed that he never received notice of the scheduling date or a copy of the "agreed order." Tr. 26. Respondent's counsel claimed that he learned of the March 2019 reinstatement by checking the Commission's computer. Tr. 26. Petitioner's counsel interjected that based on what she knew from her clerk, Respondent's counsel was notified, asking how the case would have been reinstated if Respondent's counsel was absent. Tr. 27.

The Arbitrator commented that the issue was the failure to appear on May 15, 2019. Petitioner's counsel again asserted that she had no notice and that no one knew why the case appeared on the May 3, 2019 status call. Tr. 32. The Arbitrator responded that it did not matter because the case would not have received a trial date instead of being dismissed unless Petitioner's counsel's clerk requested it, noting that the case was "above the red line." Tr. 32. The Arbitrator denied Petitioner's counsel's request for a continuance and denied Petitioner's Motion to Reinstate. Tr. 33.

On August 14, 2019, Petitioner filed a timely Petition for Review seeking reinstatement of her case. On January 6, 2020 Petitioner filed her Statement of Exceptions and Supporting Brief. On January 21, 2020, Respondent filed a Response Brief.

II. CONCLUSIONS OF LAW

Petitioner seeks review of the Arbitrator's denial of reinstatement. "'In a petition for reinstatement before the Industrial Commission, the burden is on the petitioner to allege and prove facts justifying the relief prayed. The granting or denying of the petition to reinstate rests in the sound discretion of the Commission.'" *Bromberg v. Industrial Comm'n*, 97 Ill. 2d 395, 400 (1983) (quoting *Cranfield v. Industrial Comm'n*, 78 Ill. 2d 251, 255 (1980); *Shiffer v. Industrial Comm'n*, 53 Ill. 2d 519, 521(1973); and *Zimmerman v. Industrial Comm'n*, 50 Ill. 2d 346, 349 (1972)). "The term 'abuse of discretion' has been defined as 'palpably erroneous, contrary to the manifest weight of the evidence, or manifestly unjust,' and as a decision with respect to which 'no reasonable person would take the view adopted by the trial court.'" *Village*

of Kildeer v. Schwake, 162 Ill. App. 3d 262, 276-77 (1987) (quoting *Douglas Transit, Inc. v. Illinois Commerce Comm'n*, 145 Ill. App. 3d 115, 119-20 (1986)). In the administrative context, the term also tends to be equated with arbitrary and capricious decisions. See *Greer v. Illinois Housing Development Authority*, 122 Ill. 2d 462, 497 (1988). The Arbitrator's discretion is judged by reference to the Commission's rules regarding reinstatement of cases dismissed from the arbitration call for want of prosecution, which direct Arbitrators to apply standards of fairness and equity, considering the Petitioner's grounds, the Respondent's objections, and the precedents set forth in Commission decisions. See 50 Ill. Adm. Code 9020.90 (eff. Nov. 9, 2016).

Petitioner's Motion to Reinstate and Statement of Exceptions raise several grounds, which the Commission addresses in turn. Petitioner first claims that her case was dismissed in error because she never received a Notice of Motion to Dismiss filed by the Respondent. However, the Commission's rules of practice did not require Respondent to file a Motion to Dismiss or provide notice to Petitioner thereof once the case had been on file for more than three years. Rather, the case would be set for trial or dismissed absent a written request for a continuance. 50 Ill. Adm. Code 9020.60(b)(2)(D)(i) (eff. Nov. 9, 2016).

Petitioner raises a related objection to her case appearing on the May 3, 2019 status call, claiming that she had no notice of this status date, and that no one knew why the case appeared on status call for that date instead of the status call for April or June 2019. However, the Commission's rule continuing cases on the status call for three-month intervals only applies until the case has been on file for three years. 50 Ill. Adm. Code 9020.60(a) (eff. Nov. 9, 2016). Moreover, in this case, the Arbitrator stated that this case would not have been set for trial at the May 3, 2019 status call unless it had been requested by someone in Petitioner's counsel's office. The transcript of proceedings also suggests that the clerk for Petitioner's counsel may have made such a request. Petitioner has offered no information from her clerk in support of her contentions.

Petitioner's Motion to Reinstate further alleged that the case had been settled months ago. Yet the record, when read as a whole, establishes that there was an ongoing dispute between counsel regarding the language of the proposed settlement agreement. In addition, the Arbitrator disagreed with Petitioner's counsel's claim that the Arbitrator had agreed that the disputed language was unenforceable.

Lastly, Petitioner argues that she would be prejudiced by the denial of reinstatement because Respondent had disregarded his confirmation to remove the disputed language from the settlement agreement. The protracted nature of the litigation supports the conclusion that Respondent never agreed to the removal of the disputed language. In addition, Respondent maintains that continuing the litigation following prior dismissals and reinstatements had prejudiced Respondent's ability to defend the case because it must continue to maintain reserves, track witnesses, and fund its litigation expenses.

In sum, having considered the Petitioner's grounds, the Respondent's objections, and applying standards of fairness and equity, the Commission concludes that the Arbitrator did not err in denying reinstatement of the case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's Motion to Reinstate, issued orally on July 16, 2019 as reflected in the written transcript of proceedings, is hereby affirmed.

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.

August 23, 2021

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

o: 8/5/21
BNF/kcb
045

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC000360
Case Name	SAULSBERRY, CHARLES v. HOME DEPOT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0429
Number of Pages of Decision	14
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Richard Victor
Respondent Attorney	Edward Jordan

DATE FILED: 8/23/2021

/s/Christopher Harris, 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

CHARLES SAULSBERRY,

Petitioner,

vs. NO: 17 WC 360

HOME DEPOT,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2021 is hereby affirmed and adopted.

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

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

The bond requirement in Section 19(f)(2) 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.

August 23, 2021

Christopher A. Harris
Christopher A. Harris

CAH/tdm
O: 8/19/21
052

Stephen Mathis
Stephen Mathis

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0429
NOTICE OF 19(b) ARBITRATOR DECISION

SAULSBERRY, CHARLES Case# **17WC000360**

Employee/Petitioner

HOME DEPOT

Employer/Respondent

On 2/2/2021, 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 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

2623 McANDREWS & NORGLE LLC
EDWARD JORDAN
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

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)

Charles Saulsberry
Employee/Petitioner

v.

Home Depot
Employer/Respondent

Case # **17** WC **00360**

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 Napleton**, Arbitrator of the Commission, in the city of **Chicago**, on **October 23, 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 **Two-Doctor Rule**

FINDINGS

On the date of accident, **February 5, 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 not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**15,180.36**; the average weekly wage was $**291.93**.

On the date of accident, Petitioner was **40** 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 $**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**.

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with the Respondent on February 5, 2015 and that Petitioner's current condition of ill-being is not causally related to the alleged accident on February 5, 2015. All 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

1/28/21
Date

ICArbDec19(b)

FEB 2 - 2021

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES SAULSBERRY,	)	
	)	
Petitioner,	)	
	)	Case No. 17 WC 000360
v.	)	
	)	
HOME DEPOT,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACT

Petitioner, Charles Saulsberry, testified that he was working for Respondent, Home Depot, on February 5, 2015. Petitioner worked as an order picker, assisted with deliveries and helped customers. Petitioner alleged that he was lifting bags of salt at work on February 5, 2015 and felt a "pop" in his back and that he reported the injury to his supervisor, Josh, approximately 10-15 minutes after the accident occurred. An accident report was not completed after this incident.

On February 4, 2015, the night before Petitioner's alleged accident at work, Petitioner was involved in a motor vehicle accident while he was a passenger in a taxicab. Petitioner testified at hearing that the impact of the accident was "light" and he denied that he injured his back in this motor vehicle accident. Petitioner testified that the impact was so light that the infant he was traveling with did not wake up. However, it is important to note that the evidence demonstrated that Petitioner filed a lawsuit in the Circuit Court of Cook County on November 19, 2015 for injuries sustained in that February 4, 2015 car accident. Petitioner settled this lawsuit and received a settlement. Petitioner testified that he used the funds in the settlement to pay for some of his medical bills.

Petitioner testified that he reported to work on February 5 with some stiffness in his back. He testified that after experiencing a pop lifting salt bags he sought medical treatment with Swedish Covenant Hospital's emergency room. The hospital records note Petitioner's complaints were, "MVA, lower back pain" though they also note, in pertinent part, Petitioner was "involved in a motor vehicle accident 2 days ago … No direct trauma or loss of consciousness but over last 24-48 hours follow tightening in his lower back … He lifts heavy salt bags during the day and seemed to tighten him up on him [sic] today quite a bit and that's why he came in for eval." The diagnosis was listed as back pain post motor vehicle accident.

Petitioner testified that he was referred to the Illinois Orthopedic Network by his Aunt and he saw Dr. Sajjad Murtaza on February 6, 2015. Dr. Murtaza's record states Petitioner came in for an initial evaluation of a motor vehicle accident. Petitioner went on to describe the accident to Dr. Murtaza. "The cab spun and they were forcefully jerked around and whiplashed. The patient did not feel pain immediately, however, later that night he was in an extreme amount of pain and they went to the emergency room after filing a police report." Dr. Murtaza's diagnosis was low back strain with left lower extremity pain and weakness status post motor vehicle accident. Dr. Murtaza

recommended medications, a Medrol dosepak, therapy and work restrictions of no lifting or carrying more than 25lbs. There is no mention of the any accident involving lifting bags of salt at work.

Petitioner began therapy at Northside Medical Center on February 11, 2015. Petitioner gave a history that he was involved in a motor vehicle accident and was forcefully thrown in his seat. The diagnosis was lumbago with pain and weakness in Petitioner's lower extremity. There is no mention of any lifting injury at work. Petitioner underwent therapy and chiropractic treatment at Northside Medical Center from February 12, 2015 through September 9, 2015.

Petitioner continued to follow up with Dr. Murtaza and on March 19, 2015, Dr. Murtaza's notes again state that Petitioner was involved in a motor vehicle accident when he was a passenger in a cab. Petitioner reported pain in his back and radiating pain since the time of the accident. An MRI from February 27, 2012 noted an L4-L5 3mm subligamentous posterior disk bulge and protrusion. Petitioner was recommended to undergo injections and was restricted from any work.

Petitioner saw his primary care doctor at Erie Foster Ave. Health Center on March 26, 2015. The medical record notes that Petitioner was following up after a car accident and he reported back and neck pain. Petitioner reported back and neck pain following the accident and reported that he was working two jobs when he was involved in the motor vehicle accident.

A transforaminal epidural steroid injection at L4-5 was performed on April 9, 2015. Petitioner underwent an EMG on May 1, 2015. The EMG medical records with Dr. Dixon note that Petitioner sustained a motor vehicle accident on February 4, 2015 where he was in a cab and the cab was hit on the passenger side by another car. Petitioner reported back pain since the accident. The diagnosis was status post MVA with low back pain and lower lumbar radicular symptoms. The EMG revealed left L4-5 radiculopathy and radiculitis.

Petitioner underwent a second epidural injection on June 4, 2015 and was referred to Dr. Elton Dixon for a surgical consultation on June 18, 2015. Petitioner saw Dr. Dixon on June 26, 2015 whose records show that Petitioner reported that he was injured in a motor vehicle accident while riding in a taxi and has had significant low back pain with radiation into buttock and leg. Dr. Dixon recommended a L4-5 decompression and discectomy.

The medical records of Erie Foster Medical Center show that on September 28, 2015 Petitioner complained of chronic low back pain since a motor vehicle accident in February 2015. Petitioner was advised to follow up with an orthopedic doctor at Swedish Covenant Hospital.

Petitioner returned to Dr. Dixon on October 9, 2015 and the medical records again state that Petitioner presented for an injury sustained during a motor vehicle accident and complained of low back pain. Dr. Dixon opined that Petitioner was to follow up as needed until the surgery was authorized.

Petitioner started treating with Dr. Daniel Laich of Swedish Covenant on November 19, 2015. The initial visit record states that Petitioner had neck pain and back pain that radiated to his left and right leg. Petitioner reported that he was well until February 4, 2015 when he was a passenger in a taxicab that was involved in a motor vehicle accident. The diagnosis was lower back

pain, neck pain and lumbar radiculopathy. Dr. Laich recommended therapy and gave Petitioner work restrictions.

Petitioner returned to Erie Foster Medical Center on January 24, 2016 complaining of chronic low back pain and hip pain since a motor vehicle accident. The record alleges that Petitioner's prior treating surgeon ceased ongoing treatment him when it was discovered the vehicle that struck him was found to not have insurance.

On April 28, 2016, Dr. Laich's records note that Petitioner's symptoms were status post motor vehicle accident two years before the visit. Petitioner underwent an MRI of his cervical spine on August 30, 2016 which was normal and a lumbar MRI which noted degenerative changes at L5 with no significant lumbar spinal cord stenosis.

Petitioner then saw Dr. Khalid Malik at University of Illinois Medical Center on October 24, 2016. The record states that Petitioner had low back pain that radiated to his left buttock, thigh and left calf following a motor vehicle accident. Petitioner underwent two injections with Dr. Malik, with limited improvement.

Petitioner underwent surgery consisting of a left L4-5 microtube discectomy with Dr. Laich on February 6, 2017. He continued to follow up with Dr. Laich following the surgery and underwent a course of physical therapy.

Petitioner saw Dr. Konstantin Slavin at UIC Medical Center on October 2, 2017 for a surgical evaluation. The record notes that Petitioner was suffering from back pain for several years after he was involved in a motor vehicle accident. Petitioner reported back pain and pain into his legs, mostly on the left side. Dr. Slavin opined that Petitioner did not require additional lumbar spine surgery and may be a candidate for a spinal cord stimulator trial.

On May 10, 2018, Dr. Laich's records note that Petitioner's complaints could have begun following a work-related event. Petitioner acknowledged at hearing with the Arbitrator that Dr. Laich's records first mention this alleged work injury in May of 2018. Petitioner testified that he did mention his work-related accidents to nurses at the various physician's offices but that he also suffers from anxiety which may have caused him to not provide accurate or complete accident histories. On October 11, 2018, Dr. Laich noted that Petitioner reported that he was lifting salt bags at work and was injured. Dr. Laich recommended a second back surgery.

Petitioner underwent an anterior decompression with arthrodesis at L4-5 and a lumbar decompression on November 11, 2018. Petitioner had a third surgery with Dr. Laich on September 3, 2019 consisting of a posterior L4-5 decompression and arthrodesis and L4-5 decompression.

Petitioner continued treating with Dr. Laich following the third surgery and reported that he had improvement with his radiating pain. Petitioner was recommended to begin aqua therapy. Petitioner last saw Dr. Laich on August 6, 2020 and reported left buttock pain that radiated across the left lateral thigh to his knee. He is to follow up with Dr. Laich on November 5, 2020.

Petitioner testified that he still experiences lumbar pain and wears back braces. He was wearing a large white brace while testifying and required breaks to stand up from time to time. He

complains of pain while sitting, standing, climbing stairs, and lifting over 35 pounds. He also testified that he falls due to instability and weakness of his legs. Petitioner testified that he has not returned to work since February 5, 2015. He testified that he has received short term disability, long term disability, social security disability, and is a Medicare beneficiary.

Petitioner's Deposition Testimony

On October 6, 2016 Petitioner presented for a deposition in the personal injury case related to his February 4, 2015 motor vehicle accident. Petitioner acknowledged that he testified at this deposition and that he was under oath at that time. During this deposition, Petitioner testified that he did not at that time file for workers' compensation benefits. This is evidenced by Petitioner further testifying during this deposition that on the day of the alleged work accident he was walking to the bus and felt some tightness in his back, got on the bus and felt some tightness, and felt tightness as soon as he lifted a bag. Further, he testified that when he arrived he couldn't work and told his supervisor that he was in a car accident the night before. Petitioner also testified in this deposition that he never filed a workers' compensation case because he knew that his pain wasn't from the work but that it was from the car accident. Petitioner overall testified that his back hurt as a result of his motor vehicle accident.

Respondent's Section 12 Examination and Testimony

Dr. Babak Lami saw Petitioner for a Section 12 examination on June 8, 2018 and later testified via evidence deposition . Dr. Lami is an Orthopedic Spine Surgeon who practices at Illinois Spine Institute. Dr. Lami is Board Certified with a subspecialty in spine and orthopedic surgery. Dr. Lami testified that Petitioner provided a history that he was working at Home Depot. Dr. Lami testified that Petitioner stated that he was also involved in a motor vehicle accident on February 4, 2015, when he was a passenger in a taxicab.

Petitioner stated to Dr. Lami that he had back pain after lifting bags of salt at work on February 5, 2015, the day after the motor vehicle accident. He stated that he was lifting approximately 3-4 bags of salt and each bag weighed approximately 50-60 lbs. and he felt his back pop.

Dr. Lami testified regarding Petitioner's physical examination findings. Dr. Lami found Petitioner's straight leg raising tests to be negative and that the examination was normal other than Petitioner's pain complaints. Dr. Lami reviewed Petitioner's January 23, 2018 lumbar MRI which he noted showed a disc bulge following surgery and facet arthropathy. He also reviewed an MRI of Petitioner's lumbar spine dated August 30, 2016 which showed a central disc bulge at L4-L5 and a cervical MRI, which was normal.

Dr. Lami testified that Petitioner's medical records demonstrated that Petitioner's complaints were related to the motor vehicle accident and there was only one notation of a lifting activity at work. Dr. Lami diagnosed Petitioner with mild degenerative changes at L4-L5 status post-surgery based on the MRI and review of medical records. He opined that he did not have any medical evidence to support Petitioner's subjective complaints. He testified that he was not able to find that a work-related injury took place on February 5, 2015 based upon his interview of Petitioner and the review of medical records. Dr. Lami further testified that Petitioner's current

condition of ill-being was not causally related to a February 5, 2015 work accident but was causally related to the motor vehicle accident and that there was no re-injury on February 5, 2015.

Dr. Lami authored an Addendum Report dated May 29, 2020 after reviewing additional records from Dr. Laich, including the operative reports. Dr. Lami opined that the review of these additional records did not change any of his opinions provided at the time of his initial examination.

Testimony of Dr. Daniel Laich

Dr. Daniel Laich testified via evidence deposition. Dr. Laich is a Neurological Surgeon who practices at Swedish Covenant Hospital. Dr. Laich is Board Certified and performs lumbar spine, cervical spine and thoracic spine surgery. Dr. Laich's first visit with Petitioner was on November 19, 2015. Dr. Laich testified that Petitioner initially only provided a history of a motor vehicle accident that occurred on February 4, 2015.

Dr. Laich noted that his record from May 10, 2018 states that he was seeing Petitioner for a motor vehicle accident on February 4, 2015. On August 2, 2018, Dr. Laich noted that Petitioner's complaints mentioned a work associated event, but he was not provided a new history by Petitioner. Dr. Laich testified that he learned of this alleged accident during a deposition for Petitioner's motor vehicle accident case.

Dr. Laich testified that there was no difference between the motor vehicle accident and lifting bags of salt with regard to Petitioner's lumbar spine pain and he could not differentiate on what caused the Petitioner's current condition of ill-being, but stated that Petitioner lifting bags of salt worsened his back condition. He testified that the lifting incident exacerbated Petitioner's back pain and was a contributing factor for Petitioner's current condition of ill-being.

Dr. Laich did not review any accident reports or outside medical records other than his own treatment records. Dr. Laich took a written history from Petitioner and discussed the accident with him during his office visits. Petitioner only reported a motor vehicle accident on February 4, 2015. Dr. Laich testified Petitioner never reported a work injury when he initially saw him. Dr. Laich testified that Petitioner's neck pain would be related to the motor vehicle accident. Dr. Laich acknowledged that the first report of Petitioner's February 5, 2015 work incident to him was over three years after the alleged incident. Dr. Laich testified the motor vehicle accident could be a competent cause for the lumbar spine pain complaints and could cause a herniated disc. Dr. Laich testified, however, that he specifically disagreed with the conclusions of Dr. Lami.

CONCLUSIONS OF LAW

As to Issue (C), Did an Accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of his employment with Respondent. The evidence before the Arbitrator as a whole does

not credibly support the Petitioner's claim that he sustained a compensable injury on February 5, 2015 while working for Respondent.

The Act states that Petitioner bears the burden of showing, by a preponderance of the evidence, that he sustained accidental injuries arising out of and in the course of his employment. 820 ILCS 305/1(b)3(d). It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give the testimony and resolve conflicts in the evidence, particularly medical opinion evidence. *Hosteny v. Illinois Workers' Compensation Commission*, 397 Ill. App. 2d, 665, 675, (2009).

The Arbitrator finds that Petitioner's testimony regarding the alleged February 5, 2015 accident is not credible. While it does appear that Petitioner suffered a serious injury to his back, the Petitioner's claim that his back injury was related to his work as opposed to the motor vehicle accident on February 4, 2015 – the day before his alleged work accident – is not credible. The Petitioner's testimony on direct examination was impeached on cross-examination through several inconsistent statements previously made by Petitioner during his deposition testimony taken while his motor vehicle lawsuit was pending.

The Petitioner's testimony is largely unsupported by the medical records. The Petitioner mentions lifting bags of salt while at Swedish Covenant Hospital on February 5th but the same records list the primary reason for his visit and Petitioner's diagnosis to be motor vehicle accident related. This February 5th hospital record is the only reference to a work-related accident until May 10, 2018 – three years after the date of the alleged accident. The records until then reference only a motor vehicle accident. Petitioner saw many doctors after February 5, 2015 and the medical records consistently note the February 4, 2015 motor vehicle accident. There is no mention of an alleged work injury in the records from Illinois Orthopedic Network, UIC Medical Center, Erie Foster Health Center and Northside Medical Center. The medical records do not support the Petitioner's assertion that he suffered an accidental injury that arose out of and in the course of his employment with Respondent. Further, Dr. Laich testified in his deposition that he was informed of a possible work injury during his deposition in Petitioner's personal injury case for the motor vehicle accident. Dr. Laich did not learn about Petitioner's alleged work accident from Petitioner himself .

In an attempt to recover from the fact all but one of his initial medical histories for a period of three years did not mention a work-related accident, Petitioner testified that he suffers from anxiety and may not have provided complete and accurate accident histories to his doctors. In the Arbitrator's view this would explain an initial failure to give an accurate history or sporadic inconsistencies but it is unlikely that all but one of his medical histories for three years following his accident would mention a motor vehicle and not mention a work-related accident.

Petitioner testified that he did not fill out an accident report at Home Depot regarding the alleged February 5, 2015 accident. The Arbitrator also notes that Petitioner also did not file his application for adjustment of claim with the Workers' Compensation Commission until January 5, 2017 and did not have an application on file at the time that he gave his deposition in his personal injury case for the motor vehicle accident. The Arbitrator finds it unlikely that if Petitioner had injured himself at work as alleged that an accident report or application was not filed prior to 2017.

Petitioner testified in this hearing that he did not hurt his back in the motor vehicle accident and that his injuries related to the alleged February 5, 2015 work accident. However, during his deposition in his personal injury motor vehicle accident case, Petitioner testified that he injured his back in the motor vehicle accident, that his back injuries were not related to the lifting event allegedly at work, and that he had not filed for workers' compensation benefits. Petitioner's testimony at hearing in this matter and during his deposition is markedly inconsistent. It is unreasonable for Petitioner to now claim that his back pain is work-related while previously claiming, under oath, that his injuries were related to a motor vehicle accident. The Petitioner's previous belief that his back is related to his motor vehicle accident is further evidenced by the lack of discussion of any work-related accident for a period of three years following his accident.

The Arbitrator finds that Petitioner's testimony lacked credibility based upon this conflicting testimony at hearing when compared to the testimony elicited during his deposition. His testimony at hearing is further called into question as a result of the medical records which overwhelmingly discuss a motor vehicle accident through three years of initial treatment. The Arbitrator finds that Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment with Respondent on February 5, 2015.

As to Issue (E), Was Timely Notice of the Accident Given to Respondent, the Arbitrator finds as follows:

Having found above that Petitioner failed to prove that he sustained a work-related accident, the issue of notice is moot. The Arbitrator does not reach a decision on this issue.

As to Issue (F), Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury, the Arbitrator finds as follows:

Having found above that Petitioner failed to prove that he sustained a work-related accident, the issue of causal connection is moot. Nevertheless, the Arbitrator finds that Petitioner's current condition of ill-being is not related to the alleged February 5, 2015 work accident.

The only doctor that gave an opinion that Petitioner's current condition of ill-being could be causally related to the February 5, 2015 alleged lifting event was Dr. Laich. However, Dr. Laich testified that he could not differentiate between the motor vehicle accident and the alleged lifting event regarding what initially caused Petitioner's back injury. Dr. Laich believed that lifting the salt bags exacerbated the injury received as a result of the previous night's car accident. The Arbitrator does not give much weight to Dr. Laich's opinion on causation. Petitioner's treating records shows that Dr. Murtaza, Dr. Ambrogio, Dr. Dixon, Dr. Malik, and Dr. Slavin all made statements in the medical records that Petitioner's back injury began after the February 4, 2015 motor vehicle accident. Dr. Lami, Respondent's Section 12 physician, testified that Petitioner's current condition of ill-being is causally related to the motor vehicle accident and not to any lifting event at Home Depot on February 5, 2015. The Arbitrator again notes Petitioner's testimony during his deposition where he stated that his back was already bothering him on his way to work. The overwhelming weight of the medical evidence supports the position that Petitioner's back injury was related to his motor vehicle accident.

As 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 and whether Petitioner violated the Two Doctor Rule, the Arbitrator finds as follows:

Having found above that Petitioner failed to prove that he sustained a work-related accident, the issues regarding payment of medical services, the reasonableness and necessity of medical services, and any purported violation of the two-doctor rule are rendered moot. Accordingly, the Arbitrator does not opine as to the reasonableness of medical treatment rendered, does not award any amounts for the payment of medical services, and makes no determination as to any violation of the Two Doctor rule.

As to Issue (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Having found above that Petitioner failed to prove that he sustained a work-related accident, the issue of prospective medical care is moot. Petitioner is not awarded any prospective medical treatment.

As to Issue (L), Is Petitioner entitled to Temporary Total Disability benefits, the Arbitrator finds as follows:

Having found above that Petitioner failed to prove that he sustained a work-related accident, the issue of temporary total disability (TTD) benefits is moot. Petitioner is not awarded any TTD benefits.

Entered: _____ Date: January 28, 2021

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC013878
Case Name	WIGGER, GARY v. MAYCO HOLDINGS LLC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0430
Number of Pages of Decision	14
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mary Massa
Respondent Attorney	Christopher Crawford

DATE FILED: 8/23/2021

/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

Gary Wigger,

Petitioner,

vs. NO: 19 WC 13878

Mayco Holdings, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 24, 2020, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 23, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 8/19/21
68

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0430
NOTICE OF 19(b) ARBITRATOR DECISION

WIGGER, GARY
Employee/Petitioner

Case# **19WC013878**

MAYCO HOLDINGS LLC
Employer/Respondent

On 11/24/2020, 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:

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0358 QUINN JOHNSTON HENDERSON ET AL
CHRISTOPHER S CRAWFORD
227 N E JEFFERSON AVE
PEORIA, IL 61602

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)

GARY WIGGER
Employee/Petitioner

v.

MAYCO HOLDINGS, LLC
Employer/Respondent

Case # **19** WC **13878**

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 **September 22, 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, 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 $**45,746.48**; the average weekly wage was $**879.74**.

On the date of accident, Petitioner was **71** years of age, **married** with **0** children under 18.

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

Respondent shall be given a credit of $**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 Paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**586.49**/week for the period 7/28/20 through the date of arbitration, 9/22/20, representing **8-1/7th** weeks, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$1,286.00** due and owing Dr. David Robson as provided in Sections 8(a) and 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. Respondent shall further hold Petitioner harmless from any and all subrogation claims that have been or will be asserted by United Healthcare.

The Arbitrator finds Petitioner is entitled to prospective medical care. Respondent shall authorize and pay for the treatment recommended by Dr. David Robson, including, but not limited to, hardware removal and a revised spinal fusion from L2-S1.

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

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

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

Signature of Arbitrator

11/16/20
Date

ICArbDec19(b)

NOV 24 2020

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

GARY WIGGER,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 19-WC-13878
	)	
MAYCO HOLDINGS, LLC,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on September 22, 2020 pursuant to Section 19(b) of the Act. The issues in dispute are accident, causal connection, medical bills, temporary total disability benefits, and prospective medical care. All other issues have been stipulated.

TESTIMONY

Petitioner was 71 years old, married, with no dependent children at the time of the accident. Petitioner testified he was a machinist with Respondent for 47 years. On September 5, 2018, Petitioner was installing a low-pressure pump that required him to bend over in an awkward position. His left foot slipped on oil causing him to twist and injure his back and knee. Petitioner testified he previously had a left total knee replacement and his knee hurt worse than his back immediately after the accident. He testified he rested for a minute, finished the job, and returned to the office. Petitioner emailed his boss to report the accident. Petitioner testified his back pain progressed over the weekend and he informed his boss on Monday he needed to see a doctor. Petitioner reported low back pain and numbness in his legs.

Petitioner admitted to having low back pain prior to 9/5/18; however, he has not received treatment for his back for ten years. Dr. Robson performed lumbar surgery on Petitioner in 1994 and released him from his care in 1996. Petitioner admitted to flare-ups of low back pain from 1996 through the present. Prior to 9/5/18, Petitioner had a 30 to 40-pound weight restriction due to his left knee condition and possibly as a result of his back condition. Petitioner also testified he was involved in a car accident in June 2020 where he was rear ended at a stoplight by an SUV. He went to the emergency room with a head laceration but did not have any other treatment and the accident did not have any effect on his low back condition. Petitioner stated Dr. Robson was the only doctor that had treated his low back condition.

Petitioner testified he took eleven weeks of FMLA leave beginning in June 2020 due to concerns with COVID-19. He admitted to mowing his lawn once a week while he was off work using a self-propelled push lawnmower. Petitioner has not worked since Dr. Robson took him off work on 7/28/20. Petitioner testified that prior to the accident of 9/5/18 he was able to perform his job and did not have numbness and pain in his legs. He currently has numbness and low back pain that interrupts his sleep.

Petitioner testified he was initially treated by the company doctor, Dr. Dirkers, and followed up with Dr. David Robson. Petitioner received physical therapy and injections that did not alleviate his symptoms. Dr. Robson recommends surgery and Petitioner desires to undergo same.

MEDICAL HISTORY

An accident report was filled out on 9/6/18 that indicates Petitioner was installing a low volume pump and attempting to line up the coupling. It was a "blind" fitting where he had to take it in and out a couple of times. On the last try, his foot slipped and he hit his knee on a hydraulic tank. Petitioner stated his knee hurt more than his back immediately after the accident. Petitioner reported his back started to bother him a couple hours after the accident and he reported the accident to his supervisor Azron Schnelle via email at 3:18 p.m.

Petitioner initially treated with Respondent's occupational health provider, Midwest Occupational Medicine. He provided a history of installing a low volume pump on a press when his foot slipped on oil and he twisted his back. It was noted Petitioner underwent a an L4-L5 fusion in 1994. X-rays of the lumbar spine dated 9/10/18 revealed multilevel intervertebral disc space narrowing, worse at L2-3 and L5-S1. Impression was umbosacral spondylosis and postsurgical changes. He was assessment with low back pain with radiculopathy, underlying arthritis, and status post lumbar fusion. Petitioner returned to Midwest Occupational Medicine on 9/17/18 with persistent symptoms.

Petitioner was examined by Dr. Patricia Hurford on 10/8/18. Dr. Hurford's impression was lumbar-sacral strain with right greater than left radicular symptoms, no objective evidence for radiculopathy, and status post posterior lumbar fusion at L4-5. Dr. Hurford recommended physical therapy to improve range of motion and diminish pain symptoms and corticosteroids.

Petitioner began physical therapy at Apex Physical Therapy on 10/10/18. It was noted Petitioner had decreased range of motion, decreased activity tolerance and pain with significant reports of radicular symptoms. On 10/23/18, Petitioner reported no improvement from therapy and medication. Dr. Hurford recommended a CT scan and injections at L5-S1.

The lumbar CT scan was performed on 11/13/18 that revealed extensive postoperative changes at L4-5 with posterior screw-plate fixation, with mild spondylosis at this level and no canal narrowing, severe central canal stenosis and lateral recess encroachment at L3-4 secondary to mild diffuse spondylosis with a partially calcified posterior right paracentral/foraminal/ extraforaminal disc protrusion, ligamentous thickening facet joint hypertrophy and degenerative spondylolisthesis, mild canal narrowing at L2-3 secondary to mild diffuse spondylosis with a

small posterior central disc protrusion, ligamentous thickening, facet joint hypertrophy and retrolisthesis, mild canal narrowing and lateral recess encroachment at L5-S1 secondary to mild diffuse spondylosis, tiny posterior right paracentral disc protrusion, ligamentous thickening, facet joint hypertrophy, and retrolisthesis, mild diffuse spondylosis at T12-L1 with a small left paracentral/foraminal disc protrusion, mild, grade I degenerative spondylolisthesis of L3 on L4, and multilevel foraminal narrowing.

On 12/13/18, Petitioner underwent a right L4-5 paramedian epidural steroid injection under fluoroscopic guidance. Petitioner returned to Dr. Hurford on 1/14/19 at which time her impression was status post work related injury with aggravation of underlying degenerative changes juxtafusional to L4-5 fusion. He presented with severe low back and bilateral leg symptoms. Dr. Hurford recommended repeating an injection above his level of stenosis as he obtained no relief below the level of stenosis. On 2/14/19, Petitioner underwent an L2-3 epidural steroid injection under fluoroscopic guidance. On 3/5/19, Dr. Hurford felt Petitioner had exhausted conservative care and recommended continuation of his exercise program, continued work restrictions as previously noted before his work injury and released Petitioner at MMI. He was encouraged to follow-up with his spine surgeon.

Petitioner was examined by Dr. David Robson on 5/1/19. Dr. Robson took a history of Petitioner installing a pump, slipped, and sustained injuries to his low back and knee and further developed low back and bilateral leg radiating pain, numbness, and tingling. Dr. Robson reviewed the lumbar CT scan that showed a solid posterolateral fusion at L4-5 with spondylolisthesis at L3-4 with severe spinal stenosis. He further read the CT scan as showing severe narrowing at L2-3 and L5-S1 and severe bilateral foraminal stenosis at L3-4 and L5-S1. Dr. Robson's assessment was healed fusion L4-5 with severe changes at L2-3, L3-4, and L5-S1 refractory to conservative treatment. Dr. Robson recommended removal of the hardware from the lumbar laminectomy fusion from L2 to the sacrum. Dr. Robson opined that the need for surgery was a result of the accident that he described on 9/5/18 which resulted in an aggravation of his underlying condition.

Petitioner returned to Dr. Robson on 7/28/20 complaining of low back pain with right greater than left leg numbness and tingling. Petitioner reported his workers' compensation case was denied. Dr. Robson took Petitioner off work pending surgery he recommended a year ago.

Dr. David Robson testified by way of evidence deposition on 12/5/19. Dr. Robson is a board-certified orthopedic spine surgeon. Dr. Robson testified he performed a lumbar spine surgery on Petitioner in 2006 and followed him through the healing process until he released him in February 2007. Petitioner reported that on 9/5/18 he was installing a pump and had to bend awkwardly. His left foot slipped and he developed low back and bilateral leg pain, numbness, and tingling. Dr. Robson noted Petitioner underwent physical therapy and two epidural steroid injections which gave him temporary relief, but his symptoms returned. Petitioner reported being in a lot of pain and working restricted duty. Dr. Robson testified he released Petitioner on 2/8/07 with a permanent 30 to 40-pound lifting restriction. Dr. Robson testified he examined Petitioner on 5/1/19 and found no evidence of malingering. Petitioner had tenderness in his lumbar region with 70 degrees of forward flexion. Dr. Robson reviewed the CT scan that showed a solid posterior lateral fusion at L4-5 now with Grade I spondylosis at L3-4 with severe spinal stenosis,

severe central spinal stenosis at L2-3, and severe bilateral foraminal stenosis at L5-S1. Dr. Robson recommended hardware removal, a lumbar laminectomy at L2-3, L3-4, and L5-S1 and re-instrumentation from L2 to S1, with a posterolateral fusion covering those levels. Dr. Robson also recommended an updated CT scan.

Dr. Robson opined that Petitioner had no change in symptoms from 2007 until his work accident causing his symptoms to become drastically different. Dr. Robson agreed Petitioner had some degenerative changes, specifically at L5-S1 on a scan performed years ago, but they were stable and Petitioner was living a relatively normal life. He noted Petitioner has not been able to recover with conservative treatment as a result of the 9/5/18 accident. Dr. Robson testified that the work accident was "the straw that broke the camel's back". Prior to 9/5/18, Petitioner was functioning consistently for a long period of time and managing his condition without a lot of intervention and he now requires surgery for an aggravation of his condition. Dr. Robson explained Petitioner had spinal stenosis at multiple levels. The L2-3 level where Petitioner has severe central spinal canal stenosis and the L3-4 level would have a dermatomal pattern in the anterior part of the leg, the front of the leg, the thigh, and the shin. Level L5-S1 would have impact on the back of his leg and hamstring. Petitioner reported symptoms in these areas as well as achiness in his low back and stabbing on the right side. Dr. Robson testified that the surgery he is recommending involves opening and enlarging the incision he presently has, removing the hardware, and performing a lumbar laminectomy at L2-3, L3-4, and L5-S1. He opined that a significant amount of facet joints will have to be removed to adequately decompress the spine. Due to instability, Petitioner requires a spinal fusion with a combination of bone graft and hardware from L2 to S1. Dr. Robson testified Petitioner would be homebound for one week postoperatively, then functioning with a 10-pound limit for the first four months, followed by physical therapy.

Dr. Nathan Mall testified by way of evidence deposition on 2/12/20. He examined Petitioner on 7/24/19 at which time Petitioner gave a consistent history of injury. Petitioner described lumbar pain coming on a few days after the injury. He could not stand or walk for more than 10 to 15 minutes. Petitioner acknowledged having a prior fusion in 1994 and reported he had not had any problems since 1994. Dr. Mall noted Petitioner's restrictions following the fusion and his knee replacement. Dr. Mall's physical examination revealed normal reflexes, good strength in his extremities, and a negative straight leg test evidencing no radiculopathy. Dr. Mall noted very good flexion of Petitioner's lumbar spine with limited extension. Petitioner described pain over his lumbar spine and radiation to his hips with an extension maneuver.

Dr. Mall explained that Petitioner's limited extension is typical following a fusion. Petitioner's complaints of bilateral radiculopathy showed the extent of the arthritis in his low back. X-rays revealed degenerative scoliosis and rotational deformity, and complete disc space collapse at multiple levels surrounding his fusion. He said that the discs adjacent to the fusion site were completely lost, with some room at L5-S1 disc space. At L2-3 and L3-4 the entire disc space was lost. Dr. Mall noted severe arthritis with large osteophytes present. Dr. Mall opined Petitioner likely has a genetic pre-disposition to arthritis evidenced by the fact he had knee replacements. He further explained the discs above and below a fusion site experience much more stress. The disc immediately above Petitioner's fusion site had fused on its own. At L3-4, the bones are completely in contact with one another and are no longer moving. Dr. Mall opined

Petitioner's scoliosis also contributed to his condition which can cause a worsening of arthritis. Dr. Mall also reviewed an MRI showing the nerve roots that exit the foramen were completely closed off by bone spurs. Dr. Mall diagnosed severe degenerative scoliosis and degenerative disc disease of the lumbar spine at L2 to sacrum status post lumbar fusion at L4-5.

Dr. Mall testified it is unlikely Petitioner was pain free at the time of the accident given the severity of arthritis. X-rays show Petitioner would likely have had stiffness in his low back and exhibited various postures. Dr. Mall felt Petitioner's mechanical limitations were entirely related to the arthritis in his back and Petitioner had to have experienced a stiff back given the amount of arthritis present. Dr. Mall did not feel that Petitioner's current condition was related to the incident given the severity of the arthritis and fairly minimal injury mechanism. He explained that Petitioner's history of minimal twisting would not dramatically change his arthritic back as not enough force was involved. Dr. Mall agrees Petitioner requires surgery but that his condition is not causally related to his work accident. Dr. Mall concluded that a patient following a fusion will experience flare-ups which get worse over time. Eventually the deterioration becomes so great that it affects the nerves which is happening in Petitioner's case.

On cross-examination, Dr. Mall admitted he did not perform lumbar surgeries and referred those cases to other doctors which include Dr. Robson. Dr. Mall agreed that a component of an individual's pain is a pretty large piece of the puzzle in determining the direction of care. Dr. Mall conceded that no diagnostic studies were ordered or performed for Petitioner's back in the five years prior to his work accident. Dr. Mall agreed that as of 9/5/18, Petitioner has sought medical treatment for his back and has had pain since the accident. Dr. Mall agrees that the surgery recommended by Dr. Robson is appropriate and believes Dr. Robson is a competent surgeon. Dr. Mall also agreed that objectively he did not have anything in the medical records that stated Petitioner was experiencing back pain in the five years prior to the accident. He further stated there was nothing objectively in the records evidencing Petitioner had back pain ten years prior to the accident.

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 when he slipped and injured his knee and low back. Petitioner testified without rebuttal that he suffered an accidental injury to his knee and low back on 9/5/18. Petitioner reported the accident to his supervisor via email the same day. An accident report was filled out on 9/6/18 that indicated Petitioner slipped and struck his knee on a hydraulic tank. He reported his knee hurt more than his back immediately after the accident, but his back started to bother him a couple hours later. This incident is corroborated by consistent accounts throughout his medical records. The unrebutted evidence shows Petitioner was able to perform his work duties prior to 9/5/18 without incident. Petitioner's back pain progressed to the point he sought medical treatment.

Based on the credible testimony of Petitioner and treating records, the Arbitrator finds that Petitioner sustained his burden of proof in establishing that he suffered an accident that arose out of and in the course of his employment with Respondent on September 5, 2018.

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

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury, such as a chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 197 Ill.Dec. 502, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 66 Ill.Dec. 347, 442 N.E.2d 908 (1982).

When a preexisting is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition". St. Elizabeth's Hospital v. Workers' Comp. Comm'n, 864 N.E.2d 266, 272-273 (5th Dist. 2007). Accidental injury need only be a causative factor in the resulting condition of ill-being. Sisbro, Inc. v. Indus. Comm'n, 797 N.E.2d 665, 672 (Ill. 2003) (emphasis added). Even when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in his or her current condition of ill-being. Sisbro, Inc. v. Indus. Comm'n, 797 N.E.2d 665 (Ill. 2003).

Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant's condition. Land & Lakes Co. v. Indus. Comm'n, 834 N.E.2d 583 (2d Dist. 2005). Employers are to take their employees as they find them. A.C.& S. v. Industrial Comm'n, 710 N.E.2d 837 (Ill. App. 1st Dist. 1999) citing General Electric Co. v. Industrial Comm'n, 433 N.E.2d 671, 672 (1982). The law is clear that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. Rock Road Constr. v. Indus. Comm'n, 227 N.E.2d 65, 67-68 (Ill. 1967); see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n, 362 N.E.2d 339 (Ill. 1977).

The record shows Petitioner was able to perform his job duties without incident prior to his accidental work injury on 9/5/18. There was no evidence offered other than evidence of the work accident that could reasonably explain Petitioner's onset of low back symptoms and his inability to work. Although Petitioner has a history of lumbar spine surgery and symptoms, the record demonstrates he had not treated for back symptoms for years prior to 9/5/18. Dr. Robson testified he released Petitioner on 2/8/07 with a permanent 30 to 40-pound lifting restriction and that Petitioner had no change in symptoms from 2007 until his work accident, which caused his symptoms to become drastically different. Petitioner testified he did not experience numbness in his legs prior to 9/5/18. Dr. Robson agreed Petitioner had some degenerative changes but they were stable and Petitioner was living a relatively normal life.

The Arbitrator finds Dr. Robson's opinions more credible than those of Dr. Mall in light of the chain of events and the objective medical evidence. Dr. Mall admitted he does not perform lumbar surgeries and refers those cases to other doctors including Dr. Robson. Dr. Mall conceded that no diagnostic studies were ordered or performed for Petitioner's back in the five years prior to his work accident, nor did Petitioner receive treatment for his back during that time. Dr. Mall also agreed that objectively he did not see anything in the medical records that evidenced Petitioner was experiencing back pain in the five years prior to the accident. He further stated there was nothing objectively in the records evidencing Petitioner had back pain ten years prior to the accident.

Therefore, the Arbitrator finds Petitioner's current condition of ill-being is causally related to the injury that occurred on September 5, 2018.

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

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

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001). Specific procedures or treatments that have been prescribed by a medical service provider are "incurred" within the meaning of section 8(a) even if they have not been performed or paid for. *Dye v. Illinois Workers' Comp. Comm'n*, 2012 IL App (3d) 110907WC, ¶ 10, 981 N.E.2d 1193, 1198.

Based upon the above findings as to causal connection, the Arbitrator finds that Petitioner is entitled to medical benefits. Respondent shall therefore pay outstanding medical bills due and owing Dr. David Robson in the amount of $1,286.00 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. Respondent shall further hold Petitioner harmless from any and all subrogation claims that have been or will be asserted by United Healthcare.

Further, Petitioner has exhausted all conservative means to relieve the effects of his injury without lasting relief and has not reached maximum medical improvement pursuant to the medical records and Dr. Robson's opinion. Respondent shall authorize and pay for the treatment recommended by Dr. David Robson, including, but not limited to, hardware removal and a revised spinal fusion from L2-S1.

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

The law in Illinois holds that "[a]n employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill. 1990). The ability to do light or restricted work does not preclude a finding of temporary total disability. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill., 1990) citing *Ford Motor Co. v. Industrial Comm'n*, 126 Ill.App.3d 739, 743, 467 N.E.2d 1018, 81 Ill.Dec. 896 (1984).

The record shows that Petitioner has not reached maximum medical improvement and remains under the care of Dr. Robson who took him off work on 7/28/20 pending surgery. Based upon the above findings as to accident and causation, the Arbitrator finds Petitioner is entitled to temporary total disability benefits of **$586.49**/week for the period 7/28/20 through the date of arbitration, 9/22/20, representing **8-1/7th** weeks. Respondent shall be given a credit of $0.00 in TTD benefits.

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

Linda J. Cantrell, Arbitrator

11/16/20
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC030444
Case Name	O'CONNELL, WILLIAM G v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0431
Number of Pages of Decision	15
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Charles Given
Respondent Attorney	Lucy Huang

DATE FILED: 8/23/2021

/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

William G. O'Connell,

Petitioner,

vs. NO: 17 WC 30444

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 27, 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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 23, 2021

/s/ Marc Parker
Marc Parker

MP:yl
o 8/19/21
68

/s/ Stephen Mathis
Stephen Mathis

/s/ Christopher A. Harris
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0431

O'CONNELL, WILLIAM Case# **17WC030444**
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

On 3/27/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William O'Connell
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **17 WC 30444**
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **July 23, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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 §8(e)17 credit?
O. ☐ Other _____

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$102,689.60**; the average weekly wage was **$1,974.80**.

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

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

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

Respondent shall be given a credit of **$67,146.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$67,146.60**.

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

ORDER

Respondent shall be given a credit of $67,146.60 for TTD benefits paid commencing October 6, 2017 through September 27, 2018.

Respondent shall pay Petitioner permanent partial disability benefits of **$790.64/week** for **128.11** weeks because the injuries sustained to the right shoulder caused a **17.5% loss of a person-as-a-whole** and because the injuries sustained to the right elbow caused a 20% loss of use of the right arm, reduced by 3.95% §8(e)17 credit for a **net loss of use of the right arm of 16.05%**.

Respondent shall pay Petitioner compensation that has accrued from October 5, 2017 through July 23, 2019, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 25, 2020
Date

MAR 27 2020

William O'Connell v. City of Chicago
17 WC 30444

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?; ***L:*** What is the nature and extent of the injury?; ***N:*** Is Respondent due a §8(e)17 credit?

STATEMENT OF FACTS

At the time of accident, Petitioner William O'Connell was a 53-year-old working foreman employed by Respondent City of Chicago Streets and Sanitation Department. On October 5, 2017 Petitioner injured his right shoulder and right elbow when he was lifting a manhole cover to check flow in a sewer, and felt a pop and pain in his right shoulder and right elbow. He reported his injury to his supervisor.

Petitioner was referred to MercyWorks, where he was examined by Dr. Steven Anderson (PX #1). X-rays of the right shoulder revealed degenerative changes of the glenohumeral joint without evidence of acute osseous abnormality or malalignment. X-rays of the right elbow showed moderate degenerative changes without evidence of acute fracture or dislocation.

Petitioner was diagnosed with a right shoulder strain, biceps tendinitis, right elbow strain, and ulnar neuritis. He was taken off of work. On October 11, 2017, Dr. Anderson recommended physical therapy. Petitioner received therapy at MercyWorks from October 11 through November 15, 2017.

On November 16, 2017, Dr. Anderson referred Petitioner for an MRI of the right shoulder and an EMG for the right elbow. On November 29, 2017, Dr. Anderson diagnosed Petitioner with a right shoulder partial rotator cuff tear and referred him to see an orthopedic evaluation at Midwest Orthopedics at RUSH.

On December 4, 2017, Petitioner was examined by Dr. Nikhil Verma at Midwest Orthopaedics at RUSH (PX #2). Dr. Verma reviewed the right shoulder MRI of the right shoulder and diagnosed right shoulder pain from a work injury with component of subacromial impingement, biceps tendinitis, and mild tenderness over the AC joint, as well as right elbow ulnar nerve irritation with preexisting mild osteoarthritis. Dr. Verma administered an injection to Petitioner's right shoulder and referred him for physical therapy. Dr. Verma also referred Petitioner for an EMG of the right elbow and an

evaluation of the elbow by Dr. John Fernandez, also affiliated with Midwest Orthopaedics at RUSH.

Petitioner began physical therapy for his shoulder at Athletico December 7, 2017 (PX #3).

On December 8, 2017, Petitioner underwent an EMG on the right elbow at Excel Occupational (PX #2).

Dr. Fernandez examined Petitioner on January 18, 2018 (PX #2). Dr. Fernandez diagnosed right elbow ulnar neuropathy with positive EMG, right elbow lateral and medial epicondylitis, and right elbow distal biceps tendinitis. Dr. Fernandez recommended no use of the right arm and surgery for the right elbow.

On March 23, 2018, Dr. Fernandez performed right elbow ulnar nerve release with subcutaneous transposition/cubital tunnel release. The postoperative diagnoses were right elbow ulnar nerve compression neuropathy with instability, and cubital tunnel syndrome. On April 6, 2018, Dr. Fernandez recommended physical therapy for the right elbow.

Petitioner attended physical therapy at Athletico from April 11 through July 10, 2018 (PX #3).

Dr. Verma administered a second injection to Petitioner's right shoulder May 23, 2018. On July 18, 2018, Dr. Verma recommended surgery for Petitioner's right shoulder once cleared by Dr. Fernandez.

On July 31, 2018, Petitioner was examined by Dr. Fernandez, reporting some soreness, sensitivity and clicking in the right elbow. Dr. Fernandez discharged Petitioner with respect to the right elbow, released him to full duty work with regard to the elbow, and cleared Petitioner for right shoulder surgery.

Dr. Verma performed right shoulder arthroscopic debridement and limited capsular release, chondroplasty, labral debridement, subacromial decompression with acromioplasty, and mini-open subpectoral biceps tenodesis on August 16, 2018. The postoperative diagnoses were right shoulder pain, glenohumeral synovitis with early glenohumeral arthropathy, impingement, and biceps tenosynovitis.

Petitioner attended post-operative physical therapy for his shoulder at Athletico from August 23 through December 21, 2018 (PX #3).

On September 20, 2018, Dr. Verma recommended that Petitioner to return to work full duty as a mason inspector for Respondent but continue with therapy. Dr. Verma discharged Petitioner at MMI for the right shoulder on January 14, 2019.

Petitioner testified that immediately before his October 5, 2017 accident he was not having any problems with his right shoulder or right elbow and was working full duty. Petitioner testified that he currently still has issues and aching with his right shoulder on a daily basis, particularly with activities such as mowing the lawn or lifting a gallon of milk. He often has to take breaks when the shoulder becomes more painful. He wakes up several times each night due to pain when he rolls over onto his right side. He still has tenderness in the elbow, which increases with activity at work.

Petitioner's current job duties involve inspecting the work of outside contractors, but he still has to lift occasionally. He tries to use his left arm more while working and will ask for assistance with heavier activities such as lifting manhole lids. The discomfort in his right shoulder and elbow are aggravated in colder weather. When his symptoms get worse in both the right shoulder an elbow, he treats with ice and stretching. He performs a daily home exercise program. He takes ibuprofen a couple of times per week when the pain gets more severe.

Petitioner testified he had previously injured his right arm on April 16, 2008 and filed a Workers' Compensation claim, 08 WC 019652. Illinois Workers' Compensation Commission records, note that Petitioner and Respondent resolved that claim for a lump sum equal to 3.95% loss of use of the right arm (RX #1). Petitioner did not have any permanent work restrictions as a result of his April 16, 2008 accident and returned to his full job duties.

Petitioner also testified that he has not seen Dr. Fernandez since July 31, 2018 and Dr. Verma since January 14, 2019. Petitioner also stated that he does not have future medical appointments for his right arm and shoulder.

CONCLUSIONS OF LAW

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

Petitioner testified that prior to the accident on October 5, 2017, he was not having any immediate problems with his right shoulder or his right elbow. After he lifted manhole cover while working that day, Petitioner had a pop and immediate pain in his right shoulder and right elbow. His treating physicians diagnosed injuries to his right shoulder and right elbow resulting from the work accident.

Respondent offered no evidence to rebut the causation opinions of Petitioner's treating surgeons. Accordingly, the Arbitrator finds that Petitioner proved that his condition of ill-being is causally related to his workplace accident on October 5, 2017.

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

Petitioner's permanent partial disability was assessed in accord with §8.1b:

(i) No AMA Impairment rating was admitted with regard to either Petitioner's right shoulder injury or his right elbow injury. The Arbitrator cannot give any weight to this factor.

(ii) Petitioner's occupational required heavy physical labor, including occasional heavy awkward lifting. Petitioner returned to a position as a mason inspector, which still requires occasional heavy lifting. The Arbitrator gives moderate weight to this factor.

(iii) Petitioner was 55 years old at the time of his accident. He had a statistical life expectancy of approximately 27 years. Petitioner is likely to continue to suffer from the continuing complaints and limitations he expressed at trial for the remainder of his life. The Arbitrator give great weight to this factor.

(iv) Petitioner returned to regular work duties with no evidence that he sustained any loss of earning capacity. The Arbitrator gives this factor little weight.

(v) Petitioner's medical records clearly demonstrate Petitioner's two injuries: the right shoulder and the right elbow. He came under the care of two respected orthopedic surgeons at Midwest Orthopedics at RUSH.

Dr. John Fernandez diagnosed right elbow ulnar neuropathy with positive EMG, right elbow lateral and medial epicondylitis, and right elbow distal biceps tendinitis. Dr. Fernandez performed right elbow ulnar nerve release with subcutaneous transposition/cubital tunnel release. His postoperative diagnoses were right elbow ulnar nerve compression neuropathy with instability, and cubital tunnel syndrome.

Dr. Nikhl Verma diagnosed right shoulder pain from a work injury with component of subacromial impingement, biceps tendinitis, and mild tenderness over the AC joint, as well as right elbow ulnar nerve irritation with preexisting mild osteoarthritis. Dr. Verma performed right shoulder arthroscopic debridement and limited capsular release, chondroplasty, labral debridement, subacromial decompression with acromioplasty, and mini-open subpectoral biceps tenodesis on August 16, 2018. The postoperative diagnoses were right shoulder pain, glenohumeral synovitis with early glenohumeral arthropathy, impingement, and biceps tenosynovitis.

Petitioner underwent physical therapy prior to his surgeries and then post-operatively and was ultimately released to full duty work at MMI. However, the Arbitrator notes the Dr. Verma's surgery included arthroscopy and also an mini-open subpectoral biceps tenodesis. Open surgical procedures present greater risks of complications and tend to require longer post-operative rehabilitation. Therefore, the Arbitrator gives great weight to this factor.

Determination of permanent partial disability is not a simple a calculation, but an evaluation of all evidence including the five factors set forth in §8.1b(b) of the Act. Therefore, the Arbitrator concludes that Petitioner has sustained a 17.5% loss of a person-as-a-whole for the right shoulder, 87.5 weeks, and 20% loss of use of the right arm, reduced by 3.95% §8(e)17 credit for a net loss of use of the right arm of 16.05%, 40.61 weeks.

N: Is Respondent due any §8(e)17 credit?

Respondent is entitled to a credit for prior disability of 3.95% loss of use of the right arm against the awarded permanent partial disability in this case, pursuant to §8(e)17.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC036349
Case Name	MCGAHEE, KENNETH v. CHICAGO TRANSIT AUTHORITY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0432
Number of Pages of Decision	15
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Donna Zadeikis
Respondent Attorney	Andrew Zasuwa

DATE FILED: 8/23/2021

/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

Kenneth McGahee,

Petitioner,

vs. NO: 18 WC 36349

Chicago Transit Authority,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary 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 9, 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 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.

August 23, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 8/19/21
68

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0432

McGAHEE, KENNETH
Employee/Petitioner

Case# **18WC036349**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 4/9/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0233 DePAOLO & ZADEIKIS
DONNA ZADEIKIS
309 W WASHINGTON ST SUITE 550
CHICAGO, IL 60606

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KENNETH MCGAHEE
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # **18** WC **36349**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **October 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

McGahee v. CTA, 18 WC 36349

FINDINGS

On **November 12, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**64,584.00**; the average weekly wage was $**1,242.00**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**5,277.32** for non-occupational indemnity disability benefits, for a total credit of $**5,277.32**.

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

ORDER

The Petitioner has failed to prove that he sustained accidental injury to the cervical spine which arose out of his employment with the Respondent on November 12, 2018

No benefits are awarded.

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

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

Signature of Arbitrator

April 7, 2020
Date

APR 9 - 2020

STATEMENT OF FACTS

Petitioner has been employed by Respondent as a bus driver since 7/15/02. He testified that on 11/12/18 he was injured around 7:35 a.m. on 75th Street between Stony Island and Colfax. He was running the 74th and 75th street route, which goes from 74th and Damen to 75th and the lakefront. He generally works from 6:30 a.m. to 2:45 p.m. Petitioner testified that this route, versus other routes he has driven, involved a large degree of construction, mainly between Stony Island and past Colfax, resulting in uneven road with potholes and lanes that would weave around the construction. He testified that the terrain was rough with partially filled potholes, and lots of gravel/rocks and other debris. He testified that it was the worst area of construction he has seen as a bus driver, and that he is unable to avoid the area by taking a different route.

About an hour into his shift on 11/12/18, he testified he was going across and over rough terrain, and as he was doing so he developed neck pain which got so severe he had to pull over. He was wearing a shoulder and lap seatbelt. As he went over this terrain, he testified his neck was moving slightly from side to side as he bounced over it, and he felt a jerk in his neck, which is when he started feeling the pain. It was a sudden development of pain that became excruciating, and he indicated he never had that kind of pain before. After pulling over, he called Respondent's control center to report the incident, and an ambulance came for him shortly thereafter.

Petitioner testified that on 11/8/18 he'd had slight back and neck pain, but it was not severe, and he didn't need to be off work. He testified he performed his regular job and his activities of daily living that day without issue. Petitioner acknowledged he had been involved in a prior motor vehicle accident in 2016 where someone made a left turn in front of his bus, testifying he had slight discomfort and pain in his back and neck. He was taken to the hospital, had x-rays and was off work for a week. He was advised to see a specialist but testified that nothing else was done and he went back to work after a week and had continued working since that time until 11/12/18.

Petitioner was taken by ambulance to the Jackson Park Hospital emergency room on 11/12/18, The City of Chicago ambulance report states: "Upon arrival crew observed (illegible) pt standing up right in CTA bus. Pt. states that he is the driver having neck pain that started Thursday. Patient states that no particular event aggravated his neck, denied any recent trauma. Patient states that pain radiates to the back of his head. . ." (Px2 & 3). At the ER, he reported a gradual onset of neck pain Thursday afternoon (11/8/18). A separately documented history states: "pt presented to er with c/o neck and back pain, pt is a bus driver, pt state it hurts when driving the bus, the up and down bumps, pt is lots of pain." There was no upper extremity numbness or tingling. He reported a respiratory infection a week prior and that cough and congestion had resolved with antibiotics. Morphine was provided. A cervical CT scan showed a minimally displaced butterfly fracture fragment along the ventral surface of the odontoid process suggesting an avulsion type fracture. There was mild overlying prevertebral soft tissue edema/small effusion, as well as multilevel degenerative changes, with the worst spinal stenosis being mild at C4/5 and the worst neuroforaminal stenosis being moderate to severe bilaterally. The diagnosis was cervical odontoid fracture and an MRI evaluation was recommended. Petitioner testified morphine he was given at the ER didn't help and his pain worsened, so he was transferred by ambulance to University of Chicago Hospital. The Arbitrator notes that the primary insurance listed was his PPO plan, not workers' compensation. (Px1).

At the U of C Hospital, Petitioner advised "he is a bus driver and has very bumpy ride for years." Neck pain with possible odontoid fracture was noted. The "Attending Attestation" history indicated: "5 days of neck pain, noticed more when he was driving a bus but no history of trauma." Dr. Feenstra documented that Petitioner was fine until 11/8/18 when he noticed neck pain while driving his bus. Petitioner: "States the pain is mostly right-sided, exacerbated when moving his neck around (looking around at traffic) and when going over uneven ground. He thinks the pain was caused by the rough terrain in Chicago, including many potholes and

construction ground." The note also indicates the Petitioner had been to the Mercy Hospital ER and was discharged with no pain control or diagnostic imaging, he then felt well over the weekend but began to notice the pain again when driving the bus and went to the Jackson Park ER. Yet another history was taken by Nurse Havlin of Petitioner having worsening neck pain since 11/8/18, being prescribed Valium at Mercy, which helped, and then driving his bus today with excruciating pain throughout his neck. He denied any injury or trauma. Neurologic exam was nonfocal. The diagnostic impression with cervical MRI did not identify an odontoid fracture and that "appearance is favored to reflect normal variation within the ossification center with mild degenerative type edema signal. Calcification anterior to the ossification center was better seen on CT related to calcific tendinitis of the longus colli which can be seen in the setting of calcium hydroxyapatite deposition." Otherwise there was multilevel degenerative disc disease and neuroforaminal narrowing most severe from C5 to C7. Petitioner was released: "Does not require any neurosurgical follow up. Can wear the c-collar for comfort but does not need to." Diagnosis was cervicalgia and he was advised to follow up with his primary care provider. (Px2 & 3).

In the late evening of 11/12/18 (at 21:51, according to the report), Petitioner signed off on an "Employee's Report of Injury On Duty." This document indicates that at 7:35 a.m. he sustained an injury while on an eastbound route. As to the type of injury, Petitioner stated: "While operating CTA bus 1435 as I crossed Stony Island at 75th E/B I started to feel intense neck pains. I notified control and they sent medical assistance. I also experienced similar less severe neck pains on Thursday 11/8/18 while operating bus but the pain went away so I returned to work on Monday 11/12/18." He noted he went to both Jackson Park and University of Chicago Hospitals. (Px9; Rx1). Petitioner acknowledged that he prepared this report.

A "Miscellaneous Incident Report" (dated 11/12/18) was also prepared by Petitioner and contains essentially the same information as the Report of Injury On Duty, that he began to feel severe neck pains while driving the bus that day eastbound on 75th as he crossed Stony Island. (Rx2). Petitioner testified on cross-examination that he was familiar with Rx2 and completed and signed it, and he agreed the document is required by Respondent regarding a work incident or injury. He agreed this document also does not mention anything about a bumpy road or potholes, just that he felt neck pain driving the bus. He also indicated his bus was moving between 1 and 3 mph when he was traversing the noted area.

Petitioner followed up with Dr. Milenkovich on 11/13/18. The initial report notes the Petitioner's initial ER visit (but indicated as 11/9/18), and that Petitioner had previously been to the ER on 11/5/18 for acute asthma exacerbation with acute bronchitis. He was advised to continue asthma medications and, as to neck pain, he was prescribed baclofen, a Medrol dosepak and physical therapy. It appears she also referred Petitioner to a chiropractor, Dr. Allgeier, and to orthopedic surgeon Dr. Fisher, but it is unclear if these orders were entered or were "discontinued" based on the documentation. (Px4).

On 11/21/18, Petitioner reported seeing Dr. Allgeier and that he felt the exercises and muscle relaxers helped, though he reported discomfort in the upper back and neck. Dr. Milenkovich continued ibuprofen and a muscle relaxer, advising Petitioner to follow up with Dr. Allgeier and remain off work pending 11/28/18 follow up. (Px4).

The next note the Arbitrator found in the records in evidence is an 11/21/18 discharge from Dr. Milenkovich. The discharge diagnoses included neck pain/sprain and sprain of right shoulder. However, the note also appears to indicate four weeks or physical therapy was prescribed and that Petitioner was to return for follow up. At the same time, there is an indication that Petitioner had a 12/19/18 visit scheduled at "FHC Spec East." (Px4).

On 12/12/18, Dr. Milenkovich noted Petitioner was there for completion of "return to work" forms, noting he had been released to return to work by Dr. Stiso on 12/1/18 "but did not go because he was still feeling pain in

his neck and is not able to move his neck. Pain is worse with sitting for prolonged periods of time, takes ibuprofen with minimal relief pain is in the neck and upper back, pain goes from side to side. No radiation into the arms." It further notes that he obtained an attorney who "referred him to spine specialist, attorney sent him to another doctor (Dr. Mohiuddin), he saw her and she sent him to rehab, he start rehab this week and state he is not going back to work until cleared by this new spine surgery MD." Dr. Milenkovich advised Petitioner she could not complete his work status documentation "as he is no longer seeking my advise re his condition." (Px4). The Arbitrator notes that no records of a Dr. Stiso was located in the evidentiary record, and there was no testimony regarding this physician or his involvement with this case.

Petitioner testified he next sought treatment at the Illinois Orthopedic Network and there described his job and the rough terrain he had gone over on 11/12/18 to Dr. Mohiuddin. He also testified he was provided with off work slips at this facility, which were given to the Respondent.

The initial 12/6/18 report of Dr. Mohiuddin (Anesthesiology and Pain Management) notes Petitioner was there for evaluation of a work injury: "He is a CTS bus employee. He has been doing some routes on the south side with broken, damaged roads and large potholes and he states that when the bus goes over these large potholes, there is a pretty significant whiplash injury. He states that doing this repetitively caused a very sharp right-sided neck pain with pain that starts to progressively radiate down into the right shoulder blade. He has never had an injury to the neck. He has never sought medical attention for an injury to the neck and has no prior or preexisting neck pain before reporting this accident at work." The pain did not radiate all the way down the right arm. He rated his pain at a 5/10 level and indicated it was worse with overhead lifting and movement of the head and neck. Dr. Mohiuddin diagnosed cervical spondylosis and right-sided cervical facet pain, and the plan was for Celebrex and 12 sessions of physical therapy. Petitioner was advised to stay off work. (Px5 & 6).

On 1/3/19, Dr. Chunduri (Pain Management and Anesthesiology) noted complaints of ongoing neck pain radiating to the right shoulder ("It is no longer radiating all the way down the arm as it was previously"). While he had been in therapy for 4 months and taking Celebrex, his pain remained at a 5/10 level. Noting Petitioner appeared to be having radicular symptoms initially after the accident, his arm symptoms had improved but pain was still present in his neck, Dr. Chunduri prescribed a cervical MRI and advised continued therapy and medication. Petitioner was continued off work. (Px5 & 6).

A 1/15/19 cervical MRI reflected: 1) loss of lordosis, 2) disc desiccation throughout, 3) disc protrusions at C3/4 and C5/6 with patent spinal canal and neuroforamina, and 4) disc protrusion at C6/7 with disc material and facet hypertrophy causing bilateral foraminal stenosis effacing the bilateral C7 exiting nerve roots. The history notes Petitioner complained of neck pain into the right shoulder with an 11/12/18 injury: "MVA at work." (Px5, 6 & 7).

On 1/28/19, Petitioner reported that therapy had helped significantly: though he continued to report 5/10 level pain, he reported there were times he was completely pain free. The MRI was reviewed, noting a 1-2 mm disc bulge at C5/6 causing bilateral neuroforaminal stenosis effacing the bilateral C7 nerve roots. The plan indicated by Dr. Chunduri's physician's assistant was to continue therapy and to remain off work. (Px5 & 6).

On 3/1/19, Petitioner returned to Illinois Orthopedic Network and saw physician's assistant Brittany Macleod. Petitioner reported approximately 65% improvement with therapy to date, indicating less frequent medication use down to use of Celebrex and Flexeril every other day for pain. Petitioner wasn't working but planned to return to work and overall felt improved. He was advised to attend 12 additional therapy sessions. His medications were continued, he remained off work and was to return the following month for a likely discharge at maximum medical improvement (MMI). (Px5 & 6).

Petitioner underwent physical therapy at Integrity/Illinois Rehabilitation and Spine from 12/13/19 to 4/6/19. A note dated 3/30/19 from chiropractor Dr. Hara indicated Petitioner had 3/10 level neck pain traveling into the top of the right shoulder and into the mid back. On 4/6/19, it was indicated that Petitioner continued to have mild neck pain primarily on the right that shoots into the top of the right shoulder, especially during prolonged reading (because of head positioning), prolonged sitting/driving, looking up and when turning his head from side to side. The pain was at the 2/10 to 3/10 level. Petitioner was advised to follow up with Illinois Orthopedic Network for further treatment recommendations as he had reached MMI with conservative treatment. (Px8).

Petitioner testified that he was discharged when physical therapy ended, and he was returned to work. He testified he presented to Respondent on 4/7/19 ready for duty. He was referred for a physical, fingerprints and a drug screen before being sent home that day and advised he would get a phone call. He believed he actually returned to work as a driver on or about 4/15/19, though he was not certain of this date.

Petitioner testified that he currently still notices ongoing pain 3 to 4 times a week and cannot fully turn his neck in either direction without pain. He testified that he was told by the therapist that he would have this pain. He testified he has the pain when he walks a lot, and that he tosses and turns when he's in bed. He takes ibuprofen or other over-the-counter pain medications and performs the exercises he was taught during therapy "but that doesn't tend to help a lot." He also uses hot and cold packs as well.

On cross-examination, Petitioner acknowledged that he prepared and signed Rx1 (also Px9), the Employee's Report of Injury, on 11/12/18, including that he started to feel severe neck pain driving as he crossed Stony Island (question 20). He agreed he only indicated in the report that he had been driving and that it didn't mention anything about driving over potholes. Petitioner again testified that his 11/8/18 pain had gone away.

Petitioner testified he came to see Dr. Mohiuddin because other people including bus operators have been there, and his doctor and chiropractor mentioned it, though he did not recall a particular doctor referring him there.

As to his 6/7/16 work injury (see Rx3), Petitioner agreed he signed an Application for Adjustment of Claim regarding a motor vehicle accident involving back and neck injuries. He did not recall denying prior neck problems or treatment at the Illinois Orthopedic Network, acknowledging that "if I did it was wrong."

The Application for Adjustment of Claim for case number 18 WC 36348 alleges a separate 6/7/16 motor vehicle accident involving the neck and back while working for Respondent. The Arbitrator notes that this claim was filed at the same time as the claim at bar, and both documents (along with Arbx2) were signed by Petitioner on 12/6/18. (Rx3).

Petitioner agreed that he told Brittany Caldwell on 12/21/18 that he was a chess player. He testified that when he plays chess he does sit and look at the board, but not looking down. He may have mentioned that playing chess impacted his neck, but he didn't recall telling her that he had pain due to playing chess.

Petitioner testified he did not take any photos of the road conditions he alleged caused his pain while driving the bus. He indicated that construction was going on despite the alleged accident date being in the wintertime. He testified his doctor advised him to wear the cervical collar as often as he can but agreed it was optional and that he said it would be best not to wear it if he could avoid the pain.

On redirect examination, the Petitioner testified that neither the Injury Report (Px9; Rx1) nor the Miscellaneous Incident Report (Rx2) have any questions asking about the mechanics of the accident, but agreed on re-cross that Px9/Rx1 it does ask the employee to explain how the injury occurred and what his body movements were.

He agreed that he indicated he was only operating the bus at 1 to 3 miles per hour at the intersection of the bumpy area due to the rough terrain.

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 has failed to prove that he sustained accidental injury to his neck that arose out of his employment with the Respondent. The greater weight of the evidence in the record demonstrates that Petitioner simply experienced neck pain while operating his bus on two occasions and does not demonstrate that his neck pain was caused by any aspect of his work.

The Arbitrator notes that Petitioner's various statements about the cause of his neck pain are inconsistent with each other, and further notes that Petitioner agreed that his statements concerning the claim of injury were "different." The Arbitrator does not find Petitioner's claim that driving over "rough terrain" caused his neck pain to be convincing. While the Petitioner has no choice in what route he was required to take while driving his bus on a specific run, his testimony regarding the road conditions appears to the Arbitrator to be exaggerated, as if there was a constant onslaught of unfilled pot holes and debris he had to drive over.

Initially the Arbitrator notes that the Petitioner had complaints, apparently of neck and back pain, just four days prior, on 11/8/18. Petitioner's testimony attempted to downplay his degree of pain at that time. However, it obviously was severe enough to cause him to go to the ER. Additionally, the medical records related to that incident are not included in the evidentiary record, and in the Arbitrator's view this is quite problematic in terms of verifying the Petitioner's testimony and what his exact complaints were at that time. Records of neck pain just four days prior to a claimed accident date are clearly relevant to the issues in this case. The Arbitrator also notes with interest that Petitioner referenced seeing a Dr. Stiso and being released by him to return to work, but he did not testify as to who this doctor was, where he was or when he was seen. No records were submitted into evidence that the Arbitrator was able to locate regarding this provider.

None of the Petitioner's documented initial statements regarding his neck injury are consistent with his claim that driving over rough terrain resulted in neck pain. The 11/12/18 ambulance record from the Chicago Fire Department ("CFD") indicates that Petitioner told them that no particular event aggravated his neck, and that he denied any recent trauma. It was noted in the CFD record that the injury was not work related. The Arbitrator finds it significant that there is no mention of rough terrain, gravel-filled potholes, bumps, whiplash, jerking of the neck, or construction. The two injury report statements (Px9, Rx1 & Rx2) from 11/12/18 concerning his neck pain and inability to continue operating his bus both state that Petitioner was operating his bus at 75th Street and Stony Island and started to feel neck pain. Petitioner also wrote that he had experienced neck pain previously while operating his bus on 11/8/18. These reports don't mention anything about rough terrain, gravel-filled potholes, bumps, whiplash, jerking of the neck, or construction. The Petitioner did not present any photographic or other documentary evidence reflecting the condition of the road at the location he indicated was filled with potholes.

Petitioner's story seems to change from the University of Chicago Hospital, where he reported that he had a very bumpy ride for years, to his visit with Dr. Mohiuddin, where he claimed a whiplash injury caused by driving multiple routes with broken roads and potholes, and he then testified to a single area of construction on his 75th Street route that produced severe and excruciating neck pain as he drove over it.

The Arbitrator notes that Petitioner had an acute respiratory infection the week prior to the alleged accident and was noted to have a cough. Had the Petitioner been coughing regularly in the week prior to the accident, that would also seem to be a competent potential cause of neck pain.

The fact the Petitioner may have had neck pain while driving the bus on 11/12/18 does not in and of itself prove that the pain was causally related to his driving. The greater weight of the evidence in this case seems to support the Petitioner had neck pain in 2016, had it again on 11/8/18 and again on 11/12/18, and he initially mentioned nothing about rough terrain as a cause on 11/12/18.

While the Petitioner testified on cross-examination that he did not have neck pain while playing chess, the Arbitrator notes that at every visit from 12/13/18 to 2/16/19 it was noted by Dr. Caldwell that his neck pain limited his ability to play chess. (see Px8).

Petitioner was asked on cross-examination who referred him to ION. He testified in response that his doctor and chiropractor both mentioned ION, and a number of people he knew, including bus operators, went there. Petitioner testified that he spoke with plenty of doctors and a few of them might have mentioned ION. The Arbitrator takes note that when he saw Dr. Milenkovich on 12/12/18, the doctor recounted that Petitioner said his attorney sent him to Dr. Mohiuddin (712 N. Dearborn), who practices at ION, which is located at 712 N. Dearborn in Chicago, IL. This contradicts Petitioner's testimony.

As noted, Petitioner filed a claim regarding a 6/7/18 work related vehicle accident which referenced injury to his neck and back, but on his initial visit with Dr. Mohiuddin on 12/6/18, the doctor states: "he has never had an injury to the neck. He has never sought medical attention for an injury to the neck and has no prior or preexisting neck pain before reporting this accident at work." While Petitioner said he didn't recall saying this to the doctor, he agreed if he did so it would have been incorrect.

The Arbitrator notes the above instances of inconsistent testimony and statements and concludes that Petitioner is not a persuasive witness. This is especially relevant considering that finding accident in this case would rest largely upon Petitioner's subjective statements that he encountered defects in the roads he traveled, where he initially made no mention or this, and subsequently provided no supporting objective evidence of the alleged severe road defects.

Based on the greater weight of the evidence, as explained above, the Arbitrator finds that the Petitioner has failed to prove he sustained an accident injury to the cervical spine that arose out of his employment with the Respondent on 11/12/18.

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

Given the Petitioner failed to prove a compensable accident on 11/12/18, there is no accident to which his cervical condition could be causally related.

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

Based on the Arbitrator's findings with regard to accident and causation, this issue is moot.

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:

Based on the Arbitrator's findings with regard to accident and causation, this issue is moot.

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

Based on the Arbitrator's findings with regard to accident and causation, this issue is moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC043027
Case Name	CACERES, SOL V v. CHICAGO SOUL SOCCER/ CHICAGO KICK, LLC/ DAVID MOKRY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0433
Number of Pages of Decision	42
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Scott Shapiro
Respondent Attorney	Danielle Curtiss

DATE FILED: 8/23/2021

DISSENT

/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

Sol V. Caceres,

Petitioner,

vs. No. 12 WC 43027

Chicago Soul, FC LLC,
Chicago Kick, LLC,
David Mokry, and
Dan Rutherford as State Treasurer and Ex-Officio Custodian of the
Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issues of jurisdiction, employment relationship, notice, causal connection, medical expenses, average weekly wage/benefit rates, 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 June 15, 2020, is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents 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.

August 23, 2021

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

SJM/sk
o-06/22/2021
44

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

CONCURRING OPINION

I concur with the majority's Decision and Opinion. I write separately to note my concurrence with the majority's holding that the Decision of the Arbitrator, which found Petitioner proved he sustained a compensable work accident, should be affirmed. I also concur with the finding that indoor professional soccer is extra hazardous, however, I do so for different reasons.

With respect to the automatic applicability of the enumerated enterprises or businesses which have been declared extra hazardous pursuant to Section 3 of the Workers' Compensation Act (the Act), I would analyze this issue anew and clarify the basis for finding that the playing of indoor professional soccer is extra hazardous. I would only affirm the Arbitrator's findings and conclusions that Respondent's indoor professional soccer enterprise specifically falls under Sections 3(12) and 3(17)(a).

Section 3(12) of the Act states:

> Establishments open to the general public wherein alcoholic beverages are sold to the general public for consumption on the premises.

I would find that Section 3(12) applies based on Petitioner's testimony that alcohol was sold for consumption at the Chicago Soul soccer games. Additionally, Mokry testified that alcohol was sold at most Chicago Soul games and the Chicago Soul expected to earn revenue from those sales.

Section 3(17)(a) of the Act states:

> Any business or enterprise in which goods, wares or merchandise are sold or in which services are rendered to the public at large, provided that this paragraph shall not apply to such business or enterprise unless the annual payroll during the year next preceding the date of injury shall be in excess of $1,000.

I would find that Section 3(17)(a) applies based on Petitioner's testimony that at the Chicago Soul games, merchandise and other goods were sold for the profit of the team. Mokry also testified that the team sold merchandise with its brand or logo at the games. Further, Mokry testified that he managed the payroll for the team and his annual payroll for Chicago Soul was in excess of $1,000 in 2012. The contracts of both Brisson and McKinney show that combined, their rates of pay exceeded $1,000. Additionally, the offer sheet and terms of pay provided to Petitioner in 2012 exceeded $1,000. Mokry testified that the team charter transferred from Chicago Kick to Chicago Soul at some point between August and October 1, 2012, and the team was originally chartered as Chicago Kick approximately two years before. In corroboration, a printout from the Office of the Secretary of State of Illinois submitted into evidence indicates that "Chicago Kick, LLC" was organized on August 25, 2011 and as of September 26, 2012, Mokry was one of three managers of the LLC. I would find that although Chicago Soul's first year of play was in 2012, Chicago Kick, which apparently did business as Chicago Soul, was registered and operating in 2011.

Further, I write separately to find that the Arbitrator properly analyzed the issue of automatic applicability of the Act under the "professional contact sports" case law, and to expand on this finding. Since *Bryant v. Fox*, 162 Ill. App. 3d 46, 48-49 (1987),[1] automatic applicability of the Act has been assumed or coverage almost universally elected by professional sports teams (*see Albrecht v. Industrial Comm'n*, 271 Ill. App. 3d 756 (1995)). More recently, in *Leabu v. The Lingerie Football League, LLC, d/b/a Chicago Bliss, et al.*, 15 IWCC 428, the Commission analyzed the issue of automatic applicability of the Act in terms of inherent hazards, rather than enumerated activities. In *Leabu*, the Commission affirmed and adopted the following analysis by

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[1] In *Bryant*, the appellate court explained:

> "Coverage under the Workers' Compensation Act comes about in one of two ways. First, an employer may elect to be bound by the Act. (Ill. Rev. Stat. 1985, ch. 48, par. 138.2.) The Bears did in fact elect coverage in 1982. However, the plaintiffs alleged that their injuries and subsequent treatment by Dr. Fox occurred in 1975 and 1977, several years before the Bears' election. Second, sections 3(1) through 3(18) of the Act provide automatic coverage for employers engaged in certain enumerated businesses which are declared to be ultrahazardous. (Ill. Rev. Stat. 1985, ch. 48, pars. 138.3(1) through 138.3(18).) It is this section that is in issue in the case at bar.
>
> * * *
>
> Professional sports clubs are not among the enumerated businesses. The only evidence before the trial court on this issue was a copy of a 1982 arbitrator's decision finding that the Bears were covered by subsection 17, which involves selling goods to the public. It appears that the arbitrator's decision was based on testimony by the Bears' general manager that the Bears sold 'magazine-type programs' to the public. However, the arbitrator's decision involved a claim by a player injured in 1980 and the testimony relied upon to support that decision necessarily related to the Bears' activities at that time. The plaintiffs in the case at bar alleged that the injuries and subsequent treatment by Dr. Fox occurred in 1975 and in 1977, several years prior to the time period considered by the arbitrator. Thus, even if the arbitrator's decision could be relied upon by the trial court as evidence that the Bears sold programs to the public and were therefore covered by the Act in 1980, it could not be used as support for the conclusion that the Bears were engaged in that activity at the earlier time relevant to the instant proceedings. Because the record in the case at bar contains no showing that the Bears were covered by the Act, we conclude that the trial court erred in granting the motions to dismiss on that basis and that the cause must be remanded for further proceedings in connection with that issue." *Bryant*, 162 Ill. App. 3d at 48-49.

the Arbitrator: "The Illinois Supreme Court has held that for an uninsured employer to be liable under the Act, they must be engaged in an 'extra hazardous' business or enterprise. *Fefferman v. Indust. Comm'n.*, 375 N.E.2d 1277, 1279 (1978). Section 3 of Act provides enumerated occupations that are covered because they are deemed to be 'extra hazardous,' but that list is not exclusive. The Arbitrator finds that the nature of work that the Petitioner was performing for the Respondent was extra hazardous. The Petitioner was participating in full contact, tackle football with minimal padding. The Petitioner testified credibly that she felt the job was dangerous and that she was working under the assumption that she was covered under the Illinois Workers' Compensation Act. The Illinois Appellate Court has held that 'professional football players are skilled workers contemplated under the statute.'
Albrecht v. Indust. Comm'n., 648 N.E.2d 923, 927 (Ill.App. 1st Dist. 1995)."

Accordingly, I would reaffirm the Commission's holding in *Leabu* and find the facts of the instant case to be very similar. I would specifically adopt the following analysis from the Decision of the Arbitrator:

> The Arbitrator bases this opinion on Petitioner's and both witnesses' credible detailed expert testimony and descriptions to the extra hazardous nature of professional indoor soccer, especially as compared to that of outdoor soccer. The witnesses all characterized outdoor soccer as a hazardous sport in and of itself. The Arbitrator finds all three witnesses, Petitioner, Brisson, and McKinney, were experts in the game of soccer, both indoor and outdoor, having played collegiate, national, and professional soccer, and finds their testimony supports the dangerous and extra hazardous nature of the sport. They testified indoor soccer is played on a regulation hockey rink, which is substantially smaller than that of an outdoor soccer field. The playing field is enclosed by hockey boards. Due to the boards, collisions with other players, and with the boards surrounding the field were frequent and extremely violent. The playing surface, an artificial turf placed over concrete, which was extremely hard, also made the game more hazardous, due to the speed of the ball thereby increasing the speed of the game. In addition the high speed of the game caused increased fatigue due to few or no stoppages of play making players much more susceptible to injuries. The players also did not wear pads or other protective gear, other than shin pads, compared to a hockey player who is fully padded and playing in the same enclosed playing area. These factors greatly contributed to the extra hazardous nature of the sport. For the foregoing reasons the Arbitrator finds Petitioner's work extra hazardous and falls within Section 3 of the Act.

Petitioner in the instant case, a professional soccer player, credibly testified that soccer is a hazardous contact sport, and players are susceptible to injuries. The indoor arena in the Sears Center was the size of a hockey rink, with protective boards. Because the field was smaller than an outdoor field, the pace of the game was faster, like a hockey game. "Collisions were almost every play." Because of the fast-paced, intense nature of the indoor game, players were more fatigued and susceptible to injury. Petitioner's only protection from injury was shin pads. I would find the nature of the work Petitioner performed for Respondent-employers was extra hazardous for the above reasons.

Turning to the issue of permanency, I would include an analysis of the five factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act), which states: "(i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b).

I agree with the Arbitrator that the injuries sustained caused a 45 percent disability to the person as a whole (loss of trade).

Based on the above, I concur with the majority's Decision and Opinion on Review affirming and adopting the Decision of the Arbitrator; however, I would also analyze anew, the applicability of automatic coverage under the enumerated activities in Section 3 of the Act as stated above, expand the analysis of Section 3 with additional case law, and include an analysis of section 8.1b(b) of the Act.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CACERES, SOL
Employee/Petitioner

Case# **12WC043027**

CHICAGO SOUL FC LLC/CHICAGO KICK DAVID MOKRY DAN RUTHERFORD STATE OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 6/15/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

4703 LAW OFFICE OF SCOTT B SHAPIRO
218 N JEFFERSON ST
SUITE 401
CHICAGO, IL 60661

0000 CHICAGO SOUL FC LLC
2350 HASSELL RD
HOFFMAN ESTATES, IL 60169

0000 CHICAGO KICK
DAVID MOKRY
5333 PRAIRIE STONE PKWY
HOFFMAN ESTATES, IL 60192

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sol Caceres
Employee/Petitioner

v.

Chicago Soul FC LLC/Chicago Kick; David Mokry; Dan Rutherford State Officio Custodian of the Illinois Injured Workers' Benefit Fund
Employer/Respondent

Case # **12** WC **43027**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **March 10, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/3/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**9,900.00 plus a one time payment of $200.00 for room and board**; the average weekly wage was $**425.90**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Medical benefits
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$1,740.00** to **ACE ACUPUNCTURE CLINIC**, **$10,094.08** to **WISCONSIN BONE & JOINT**, **$2,133.93** to **GLENDALE ANESTHESIA**, **$12,679.26** to **FROEDERT HOSPITAL**, **$2,164.39** to **FROEDERT HOSPITAL**, **$824.92** to **OPTIMUM OUTCOMES/FROEDERT HOSPITAL**, **$13,504.18** to **OPTIMUM OUTCOMES/FROEDERT HOSPITAL**, **$17,668.18** to **AMERICOLLECT/ORTHOPAEDIC HOSPITAL OF WISCONSIN**, **$1,557.19** to **MHFS COLLECTION/FROEDERT HOSPITAL**, **$2,400.96** to **MHFS COLLECTION/FROEDERT HOSPITAL**, **$2,164.39** to **MHFS COLLECTION/FROEDERT HOSPITAL**, and **$2,655.16** to **MHFS COLLECTION/FROEDERT HOSPITAL**, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $**283.93**/week for **42 and 5/7ths** weeks, commencing **October 4, 2012** through **July 29, 2013**, as provided in Section 8(b) of the Act.

Permanent Partial Disability
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 **45% loss of use of person** or **$57,586.50 ($255.94 rate x 225 = $57,586.50)** due to loss of trade pursuant to Section 8(d)(2) of the Act.

Injured Workers' Benefit Fund
The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation

obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

06-15-20
Date

JUN 15 2020

DECISION OF ARBITRATOR
SOL CACERES
v.
CHICAGO SOUL, FC LLC/CHICAGO KICK; DAVID MOKRY/DAN RUTHERFORD
STATE OFFICIO – CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
IWCC No.: 15 WC 8076

STATEMENT OF FACTS

Petitioner, Sol Caceres (hereinafter "Petitioner"), was employed as a full time professional indoor soccer player by Chicago Soul FC LLC (hereinafter the "Soul"), a professional indoor soccer team located in Hoffman Estates, Illinois, and playing in the Major Indoor Soccer League (hereinafter "MISL"). Also present at trial was counsel for the Attorney General representing the Injured Workers' Benefit Fund, and David Mokry (hereinafter "Mokry"), the owner of the Chicago Soul/Kick, and also named individually as a Respondent, and appearing on his own behalf and on behalf of the Soul/Kick in this matter.

Petitioner testified he was brought to Chicago from his family's home in Milwaukee, Wisconsin to play for the Soul after participating in a number of tryouts and scrimmages. (T.17-18; 100). Petitioner testified he had extensive experience as a soccer player. Petitioner began playing soccer at 5 years old; played Division One soccer for Indiana Purdue University in Indianapolis; played Division One soccer at University of Wisconsin, Milwaukee; and played as a member of the Olympic qualifying U23 Puerto Rico National Team. Petitioner testified based on his extensive experience he considered himself an expert in the game of soccer. (T. 19-20).

Petitioner was invited by Respondent to participate in several tryouts and scrimmages before being invited to play for the Soul. (T. 17-18). Petitioner testified he performed well at the tryouts, and also scored a goal in the one scrimmage game. (T. 17-18). Based on his performance at try outs and in combines, and based on his prior experience, Mokry, the team's owner, personally called Petitioner and invited him to play for the Soul as its starting midfielder

sometime in September of 2012. (T.17-18, 41-45, 49-50). Playing for the Soul was his first professional soccer experience. Petitioner also stated he had never played indoor soccer before. (17-18). Petitioner stated being hired to play professional soccer was the most momentous occasion of his life. He testified he recalled the exact moment of receiving the call sitting in his parents' home, and recounted the joy, excitement, and pride he enjoyed with his family at that time. (T-49-50). He testified he and his family celebrated as they believed it was the beginning of something very special. (T 49-50).

After receiving the phone call from Mokry, Petitioner received a number of emails from Mokry, and the Director of Public Relations/Director of Communications, Ms. Payal Patel (hereinafter "Patel"), which contained his monthly salary, bonuses, and incentives. (T. 41-46; PX 23). Mokry testified Patel worked for the Soul in various capacities, under his direction, and also ran much of the day to day office operations of the team. Mokry was also carbon copied on all communications. (PX 23, 24).

After signing the contract in Hoffman Estates with Mokry, Petitioner received a second email welcoming him to the team. (T 46-50; PX 24). This email also contained instructions for employee housing which the team provided for its players as of October 1, 2012. (PX 24). Petitioner testified he lived in the employee housing/team house with other team members, and were hosted by an Italian family who owned the house. (T. 55-56, 114). The email further outlined the practice schedule, training camp schedule, and stated practices were mandatory for all players. This email also specified the initial pay period began October 1, 2012, and the season was to be six months in duration, ending approximately in August of 2013. (T. 13; PX 24). Introduced into evidence was also two contracts of two other players, Chris Brisson, and Judson McKinney, which detailed the pay period starting on October 1, 2012, and ending March

1, 2013. (PX 30, 31). Both players testified on behalf of Petitioner as well and confirmed the terms of the payment period.

Petitioner testified regarding his trip to meet Mokry in person, and sign the contract at the team headquarters in Hoffman Estates. Petitioner described the signing of the contract, and described Mokry's office in detail. (T. 49-50). The signing was memorialized with photographs of Petitioner and another team player, Amilocar Herrera (hereinafter "Herrera"), executing the contract in Dave Mokry's office in the Sears Center. (PX 21; T. 50-54). Petitioner and the Petitioner's witnesses described and identified the office, the office location, the color of the office, the windows in the office, and the office furniture in detail in their testimony. (T-50-51; PX 21, 21A). The occasion was also memorialized with photos of Petitioner and wearing the team logo/t-shirt, and photos of Petitioner with Payal Patel, the Director of Public Relations/Director of Communications for the Soul. (T. 44-55; PX 21, 21C). Petitioner testified it was the single most momentous day in his career as he finally was playing professional soccer. He testified he dressed up in a formal shirt and tie for the signing. (T.49-54). Petitioner testified he never received a copy of the contract from Mokry, despite numerous attempts in person and via the telephone to obtain a copy. Petitioner testified Mokry made various excuses over time for not providing him with the contract, such as the copier was broken, and eventually stopped returning Petitioner's calls all together. (T. 85, 124, 127).

Petitioner travelled back to Chicago on or about October 1, 2012, and moved in to the team home with the other players who required housing. (T. 56). He immediately began attending all team functions, including a marketing event which the owner, Mokry, memorialized with a photograph which he sent out publicly via Twitter indicating it was a photo of the 2012-2013 Chicago Soul Roster. (T. 54-55; PX 21-D).

Two of Petitioner's teammates, Christopher Brisson (hereinafter "Brisson") and Judson McKinney (hereinafter "McKinney") testified on Petitioner's behalf. (T. 144-180, 187-211). Both witnesses confirmed, other than attending the Workers' Compensation proceedings, they had not been in touch with Petitioner since playing with him on the team. Brisson testified he first met Petitioner on October 1, 2012, or October 2, 2012, the days before the first practice which was to take place on October 3, 2012. (T. 145). Brisson testified he was one of the older players on the team and a veteran player in the MISL. He also testified as to his qualifications as a professional soccer player, and an expert in the game. Brisson played four years of Division One Soccer at University of Wisconsin Milwaukee; and six years as a professional soccer player for the Minnesota Thunder, the Chicago Storm, and then in the MISL for the Chicago Riot prior to joining the Soul in 2012. (T. 154). He also coached for the Minnesota United professional soccer team, and coached youth soccer for 10 years for the Chicago Fire Juniors, and Plainfield Soccer Club. (T. 155). He testified he considered himself an expert in the game of soccer. (T. 155). Brisson also signed a contract with the Soul, a copy of which was entered into evidence. (T. 147; PX 30). Brisson testified as to the terms of the contract, the commencement date of the October 1, 2012, and the payment and playing periods contained in Schedule A of his contract. (T. 147, 167-168).

McKinney also testified on behalf of Petitioner. (T. 187-211). McKinney testified he was the number one overall MISL draft pick in 2012, and hired in an open combine put on by the league. (T. 188). He joined the team after participating in a league combine on or about October 12, 2012, slightly later than some of the other players. (T. 188,190). McKinney testified to his experience as a soccer player. He testified he played all his life, played Division One soccer for The University of Cincinnati; and the U.S. National team, prior to joining the Soul. (T. 193). He

coached with the Chicago Fire for 8 years, and at the time of trial was a coach for the MLS Colorado Rapids, a professional soccer team. (T. 193). He testified he also considered himself extremely knowledgeable in the game of soccer and an expert in the game. (T. 194). A copy of his contract with the Soul was admitted into evidence, and he testified consistently to the terms of the contract and the signing process as did Brisson. (T. 189-190; PX31). McKinney stated prior to joining the Soul, he too had never played indoor soccer. McKinney testified upon arriving on the team he also lived at the employee housing, and confirmed he lived there with Petitioner. (T. 191). McKinney testified as to the signing process with the team, and his experiences signing contracts with previous teams versus signing waivers. (T. 189-190). He testified no player would dress in a formal shirt and tie to merely sign a waiver, and that one would dress up anytime one signed a contract, because usually it was more formal, and there would be photo opportunities. (T. 206-208). He also identified the person with Petitioner in the photos as Herrera, another player employed by the team. (T. 204-205, PX 21E). McKinney was also asked to identify the contract he signed, and compare it to the photograph depicting Petitioner signing. (T. 204-205). McKinney cleary identified the document Petitioner was signing in the photograph was the contract McKinney had signed. (T. 204-205; PX 21E, PX 31).

Petitioner, Brisson and McKinney all testified consistently about the inherently dangerous nature of indoor soccer, and that is was disproportionately aggressive and dangerous as compared to outdoor soccer. (T. 23-39, 156-159, 195-196). They all confirmed the manner in which the game was played, and the playing field/surface. All three testified the game was played in a hockey rink, with boards and glass akin to hockey. The surface was indoor turf laid over concrete where the ice would be for hockey. The surface was much harder than outdoor soccer, and made the ball move much more quickly. The ball also could come from any

direction because of the boards, which made the game more dangerous. The game was a non-stop physical play, with the players taking shifts as one would do in hockey by jumping in and out of play from the bench. The game was much faster than regular outdoor soccer. Due to the greatly reduced playing area, speed of the game, and boards, collisions were more frequent both with other players and the boards (as in hockey) and much more violent. The players all wore sharp cleats, and other than shin pads, wore no other protective equipment. Due to the speed of the game, fatigue was also a greater issue because the players sprinted the entire time. They all testified that due to fatigue, a player is more likely to be susceptible to injury.

Petitioner and Brisson consistently testified they had been present at various times and watched the rink/field erected, maintained and constructed. The field was constructed utilizing heavy electric or gas powered lifts, and machinery which was employed to construct the boards, and lay the turf. (T. 41, 58). They testified the boards were also present to protect the public spectators from being struck by the ball while in play. They testified the team provided at least one trainer. The trainer would tape their ankles and other body parts (both during practice and in games). The trainers would use scissors, a sharp instrument, to remove the tape. (T. 23, 158). They also testified food was sold for consumption both at practice, and at the games, as well as alcohol being sold at the games. (T. 260). Also for sale was merchandise containing the team logo.

Mokry, represented himself, and testified on his own behalf and on behalf of the Soul. He confirmed he owned the Soul. (T. 271). As owner he testified he signed all contracts and was in charge of the players and in charge of all aspects of the team, including signing players, the financial aspects of the team, signing the leases with the playing and practice facilities, as well as contracting the personal trainers and the team physicians Midwest Bone & Joint. (T.

221-228, 254-260, 265). He denied Petitioner was ever on the team, and denied Petitioner ever signed a contract. (T. 236). He testified they signed many players, and then cut them prior to starting the season, and did so regardless of whether they had signed a contract. (T. 224, 236, 243, 244). Mokry testified the photos to which Petitioner and Petitioner's witnesses testified merely depicted Petitioner signing a waiver and it was not a contract signing. He denied Petitioner was signing the contract in the photo. Mokry also alleged in his testimony that the photo of Petitioner, Herrera and Patel, was taken because all three had attended Marquette University together. (T. 213). Petitioner disputed this and testified he went to University of Wisconsin, Milwaukee. (T. 19-20, 212). Mokry also alleged Petitioner, upon presenting to the team, had been icing his knee, and was already injured. Petitioner denied such allegations. Brisson in his testimony corroborated Petitioner was not injured prior to the date of accident, and disputed Mokry's allegations. Mokry did confirm Petitioner lived at the employee housing until he evicted Petitioner after Petitioner was injured. (T. 257; 243).

Mokry confirmed team merchandise, food, and alcoholic beverages were sold at the game, confirming the testimony of Petitioner and Petitioner's witnesses. Mokry also testified the team was to share in the food and beverage sales. He also testified his payroll was greater than $1,000.00, and the team agreed to abide by any and all local, municipal and state regulations at all times. (T. 258-260). He also confirmed he did not have workers' compensation insurance. (T. 261).

Both of Petitioner's teammates testified and confirmed Petitioner was on the team, and employed as the starting midfielder. (T. 145, 190). Brisson testified, as did Petitioner, the start date of their employment was October 1, 2012, and the end date was August 31, 2013, as evidenced in Schedule A of his contract, which is why he first met Petitioner on October 1, 2012,

or October 2, 2012 at a team meeting. (T.145-146; PX 30). Brisson also identified himself in the team roster photograph, along with Petitioner, and confirmed the photo depicted the team's players. (T. 169-170; PX 21-D). He also confirmed the individual pictured with Petitioner during the contract signing was Amilocar Herrera, another player signed to and employed by the team. (T. 171). Mokry denied the picture was actually of the team's players, and alleged not everyone in the picture was actually a player, contrary to Petitioner's, Brisson's, and McKinney's testimony. (T. 173-174).

The Attorney General, representing the Injured Workers' Benefit Fund, also cross examined Petitioner, Mokry, and Petitioners' witnesses. The Attorney General also cross examined Petitioner regarding his employment by Respondent.

Petitioner testified he attended the first practice on October 3, 2012. (T. 53). Brisson offered consistent testimony confirming Petitioner attended the practice on that date. Brisson, McKinney, and Petitioner testified only players actually on the team attended the practices. (T. 58, 150). Petitioner testified he woke up at his normal time around 7 a.m., with no injuries or other medical conditions. (T. 59). Brisson and Petitioner all testified practices were weekdays beginning at 9:00 a.m. for approximately two hours a day, with games on the weekends. (T. 20, 150). They would be required to travel for the games to various other cities. The team provided a transport van to bring the players to and from practices from the employee housing provided by the team. (T. 141-142). The van was driven by one of their teammates. (T. 141-142).

At practice on October 3, 2012, Petitioner testified they were playing a scrimmage game on the field. (T. 58.) He testified the ball came to his feet, and as he went past another much larger player, the player grabbed him from behind, forcefully put all of his body weight on Petitioner's back and shoulders, and Petitioner heard a snap in his left knee. (T. 59). Petitioner

felt immediate instability and shooting pain in his left knee and left leg. Brisson confirmed in his testimony the exact same mechanism of accident and events leading to Petitioner's injury. (T. 151, 159).

Petitioner testified he had never been injured like that before, nor ever felt that type of pain in his leg previously and immediately reported to the trainer. (T. 60). The trainer performed a ligament test on his knee, advised him he may have torn a ligament, and he needed to go to the doctor. (T. 60-61). Petitioner testified he immediately called Mokry to advise him of the injury. (T. 61). Mokry provided inconsistent testimony whether he was actually attending that practice or not. (T. 90). Regardless, Petitioner testified he called Mokry, because Mokry was the team representative with whom he had interacted the most, and because he was the owner of the team Petitioner relied on Mokry to seek his advice. (T. 62-63). Petitioner advised Mokry the trainer thought he sustained an ACL tear, and he needed to get to a doctor. Mokry advised him he would schedule a doctor's appointment for him, and "figure out what to do." (T. 62-65). Petitioner testified that was the last time he played for the team, although he did return after the injury to attend games with his teammates. (t. 126, 131, 140). He testified at no time was he advised he was no longer a part of the team or no longer employed by the team. (T. 140).

After approximately one week of waiting Mokry directed Petitioner to go to Midwest Bone & Joint, the team's doctors. (T. 65). Petitioner eventually saw orthopedic surgeon, Dr. Seeds on October 8, 2012. (T.64-68; PX 1). Dr. Seeds ordered an MRI immediately and restricted Petitioner completely from all activities. (PX 1). Petitioner testified he immediately notified Mokry via telephone of the results of the examination. (T. 67). Petitioner followed up with Dr. Seeds post MRI who confirmed Petitioner sustained an ACL tear in his left knee, and advised him that he needed surgery. (T. 67; PX 1).

Petitioner contacted Mokry again and notified Mokry he needed surgery. Petitioner testified upon notifying him that he needed surgery, Mokry told him he immediately needed to leave the team house where he was living. (T.67-68). Petitioner asked what he should do about the surgery, and Mokry advised him the team would pay for it, and the team had insurance (T. 69-71). Petitioner testified he could not continue to see Dr. Seeds because Mokry would not confirm if he would pay for the surgery. (T. 69). Petitioner continued to pursue Mokry regarding the surgery and insurance coverage. (T. 69-70). Petitioner testified Mokry increasingly became harder and harder to contact. (T. 69). He testified when Mokry did answer his calls he would tell him the surgery was going to be scheduled. Petitioner inquired as to insurance for the team, and subsequently discovered there was no workers' compensation insurance coverage. (T.67-69). Petitioner advised at that point he had already left the team housing and returned to his parents' home in Milwaukee because Mokry had evicted him. (T.70). Petitioner also tried to speak to Midwest Bone & Joint who advised him they needed surgical authorization from Mokry, which is how Petitioner discovered there was no insurance coverage.

Petitioner testified his parents stated he could not wait any longer for surgery, placed him on their personal insurance, and he resumed care with an orthopedic physician in Milwaukee, Dr. Middleton, of Wisconsin Bone & Joint. (T.71-72, PX2). Petitioner underwent surgery on December 13, 2012, over two months after his accident. (T. 72; PX 2). Dr. Middleton continued Petitioner's restrictions both preoperatively and postoperatively (T.72, PX 2). Petitioner attended therapy at Froedert Hospital, and the Rossman Clinic. Dr. Middleton referred Petitioner to both facilities. (T. 73). Petitioner continued to follow up with Dr. Middleton until July 29, 2013, when he was released from care. (T. 74; PX 1).

Petitioner testified he utilized his family's group insurance to obtain the surgeries. (T. 74). He testified he would have continued therapy and care with the doctor, however after discovering it was a work related injury, his parents' insurance revoked all payments to the medical providers stating he was not covered because it was a work related injury, thereby leaving Petitioner with all of the bills as unpaid, and no way of obtaining further treatment or care. Petitioner testified all his medical bills remained unpaid. (T.77-78).

Petitioner testified he did not work anywhere else during the time he was restricted and was left without income (T. 73-76). After Dr. Middleton released him on July 29, 2013, Petitioner attempted to return to playing soccer. He signed with another team in the MISL. He testified his knee was much weaker, his balance was not as good, he was less flexible, and he was no longer as fast as he was prior to the injury. He could not perform at the professional level of which he performed previously. (T.79). Because of this, he had to take a pay cut to try to keep playing, and then was eventually asked to leave the team to which he had signed. (T. 80).

Petitioner testified at the time of trial he still has pain around his left knee, and experienced numbness and tightness in his knee which he had never felt before his injury. (T. 80). Petitioner went on to teach kindergarten in North Carolina where he currently resides. Other than a few attempts at recreational pickup games, petitioner never played soccer again. (T. 79-80).

DECISION OF ARBITRATOR
SOL CACERES
v.
CHICAGO SOUL, FC LLC/CHICAGO KICK; DAVID MOKRY/DAN RUTHERFORD
STATE OFFICIO – CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
IWCC No.: 15 WC 8076

Analysis and Conclusions of Law

A. Regarding whether Respondent was operating under and subject to the Illinois Workers' Compensation, the Arbitrator finds as follows:

The Arbitrator finds Respondent, Chicago Soul and David Mokry were operating under and subject to the Illinois Workers' Compensation Act. The Arbitrator finds Respondent Soul, and finds Respondent Mokry liable for Petitioner's injuries.

Both Respondent Mokry, and the IWBF's counsel attempted to contest whether the Soul and Respondent and Mokry were operating subject to the Illinois Workers' Compensation Act (hereinafter "the Act"). Petitioner testified he signed an employment contract in Illinois, which is sufficient to provide jurisdiction under the Act. Respondent Mokry, and the IWBF'S counsel disputed Petitioner ever signed a contract for employment. The Arbitrator find's Mokry's testimony not credible, and the attempts to discredit whether Petitioner signed the contract by IWBF not credible. The Arbitrator specifically finds the Petitioner's testimony, and the testimony of Petitioner's witnesses regarding this issue extremely more credible than that of Respondent, and gives no weight to the testimony of Respondent. Pursuant to Section 1(b)(2), the signing of an employment contract in Illinois affords jurisdiction under the Act as performed by Petitioner. The Arbitrator finds Illinois has jurisdiction in this matter.

Petitioner testified he met in person with Respondent Mokry at Respondent's place of business, the Sears Center in Hoffman Estates, after receiving an email containing an offer with the terms of his employment by Respondent. Petitioner testified he went to Mokry's office, and

described in detail the exact location of the office and the description of the interior of the office. Petitioner's witnesses, both of whom also signed contracts with Mokry, described Mokry's office and the signing procedure corroborating Petitioner's testimony. Entered into evidence as group exhibit PX 21 is a photo of Petitioner signing the contract with Mokry. Depicted in the photograph is Petitioner, dressed in a dress shirt and tie, sitting alongside Herrera another player from the team as confirmed by Petitioner, Brisson, and McKinney. The photograph shows Petitioner signing a multipage document. Both witness Brisson's and witness McKinney's contracts were entered into evidence. (PX 30, PX 31). In comparing their contracts, in particular the logo at the top of the page, along with the structure of the wording and paragraphs on the pictured document's page, the Arbitrator finds it clearly depicts the document Petitioner signed was the contract to play for the Soul. Both witnesses also testified, based upon their own experience signing with the Soul, and comparing the photo to their own contracts, and confirmed the document in the picture was the actual contract. Petitioner further testified he requested a copy of the contract on numerous occasions and Mokry refused to provide a copy. The Arbitrator finds Mokry intentionally withheld the document from Petitioner, and finds Mokry's actions in this regard to be deceptive with the intent to bolster his non-credible testimony that Petitioner was not actually signed to the team, and to attempt to evade liability for Petitioner's injury.

The IWBF attempted to discredit Petitioner's testimony by questioning him regarding a roster that did not contain his name. The roster was from the wrong season, and the wrong team. The IWBF's allegations Petitioner did not sign the contract was also not credible and failed to establish any evidence Petitioner had not signed the contract and failed to establish Petitioner was not an employee of Respondent. The Arbitrator finds based on the credible testimony of

Petitioner, Brisson, McKinney, as well as the photographic evidence admitted at trial Petitioner signed a contract for employment with the Soul.

Pursuant to Section 3 of the Act automatic coverage applies to any employer, business, or enterprise which are considered "extra hazardous." The Act enumerates 20 such enterprises or businesses which qualify for automatic coverage of the Act. The Commission has held this list is not exclusive. The Commission has held professional contact sports such as American football is considered "extra hazardous" within the meaning of Section 3, due to the substantial contact and potential for injury within the game. The Arbitrator finds the type of work being performed by Petitioner, the playing of indoor professional soccer for Respondent is extra hazardous.

The Arbitrator bases this opinion on Petitioner's and both witnesses' credible detailed expert testimony and descriptions to the extra hazardous nature of professional indoor soccer, especially as compared to that of outdoor soccer. The witnesses all characterized outdoor soccer as a hazardous sport in and of itself. The Arbitrator finds all three witnesses, Petitioner, Brisson, and McKinney, were experts in the game of soccer, both indoor and outdoor, having played collegiate, national, and professional soccer, and finds their testimony supports the dangerous and extra hazardous nature of the sport. They testified indoor soccer is played on a regulation hockey rink, which is substantially smaller than that of an outdoor soccer field. The playing field is enclosed by hockey boards. Due to the boards, collisions with other players, and with the boards surrounding the field were frequent and extremely violent. The playing surface, an artificial turf placed over concrete, which was extremely hard, also made the game more hazardous, due to the speed of the ball thereby increasing the speed of the game. In addition the high speed of the game caused increased fatigue due to few or no stoppages of play making

players much more susceptible to injuries. The players also did not wear pads or other protective gear, other than shin pads, compared to a hockey player who is fully padded and playing in the same enclosed playing area. These factors greatly contributed to the extra hazardous nature of the sport. For the foregoing reasons the Arbitrator finds Petitioner's work extra hazardous and falls within Section 3 of the Act.

In addition to the extra hazardous nature of the game of professional indoor soccer, the Arbitrator finds Respondent falls under several other of the enumerated businesses under Section 3, specifically Section 3(8). Section 3(8) states automatic coverage applies to any enterprise in which sharp edged cutting tools are used. Petitioner, and both witnesses testified Respondent's representatives utilized scissors to cut off the tape which they would tape various body parts in order to play indoor soccer. The players also testified they wore cleats, which are also sharp instruments. The use of scissors, and cleats, both sharp instruments, confers automatic coverage under Section 3(8).

Automatic coverage also applies pursuant to Sections 3(1). This paragraph of Section 3 states the erection, maintaining, removing remodeling, altering or demolishing of any structure provides automatic coverage under the Act. Section 3(15), also states any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation of the business provides automatic coverage under the Act. Petitioner and Petitioner's witnesses testified as to how the playing field and practice field, as well as the surrounding structure was erected, maintained and removed. They testified they had all been present when the playing/practice field was erected by large forklifts, or other power driven lifts to erect, maintain and remove the playing field, thereby falling under Section 3(1) and 3(15).

The Arbitrator also finds Section 3(12) applies as this section enumerates automatic coverage where an establishment is open to the general public and alcoholic beverages are sold to the general public of consumption on the premises. Petitioner and both witnesses testified alcohol was sold for consumption at the soccer games. Mokry testified the Soul was to participate in the revenue from the sale of alcohol at their games and alcohol was sold at the games. The sale of alcohol, and the fact the Respondent profited from such sales also allows for automatic coverage pursuant to Section 3(12).

Section 3(17)(a) also applies and provides automatic coverage. This Section provides automatic coverage of the Act for any business or enterprise in which goods, wares or merchandise are sold to the public at large, and the annual payroll of the enterprise preceding the date of the of injury is in excess of $1,000.00. Although it was the first year of play for the team, Mokry testified his annual payroll was in excess of $1,000.00, and the team charter was transferred from the Kick to the Soul, and therefore was in operation the year prior to Petitioner's accident. The contracts of both Brisson and McKinney show what their rates of pay were, which exceeded $1,000.00. The offer sheet provided to Caceres, and the terms of his pay were also evidence the payroll exceeded $1,000.00. The Arbitrator finds the evidence taken together with Mokry admitting his payroll exceeded $1,000.00, provides automatic coverage under the Act.

Section 3(9) also applies and creates automatic coverage. This paragraph of Section 3 states any enterprise in which statutory or municipal ordinance regulations are imposed for the regulating, or guarding of the public gives rise to coverage. Mokry testified he was subject to all municipal regulations and ordinances. Paragraph 9 goes on to state the placing of machinery or appliances for the protection or safeguarding of the public also gives rise to automatic coverage. Petitioner and Petitioner's witnesses all testified the boards surrounding the playing field also

provided protection to the public spectators watching the game. The Arbitrator finds automatic coverage applies under Section 3(9) as well.

Finally, the Arbitrator also finds Section 3(14) of the Act applies because Mokry, Petitioner, and Petitioner's witnesses testified food was sold for consumption on the premises in the form of concessions. All concessions generally utilize slicing instruments, hot water, hot grease, hot foods/substances or fluids. Mokry testified the Soul was to participate in this revenue, once again giving rise to automatic coverage pursuant to Section 3.

Based on the foregoing, the Arbitrator finds Section 3 of the Act provides automatic coverage to Respondent and Respondent is liable for Petitioner's injuries. The Petitioner and Petitioner's witnesses all provided credible testimony as to the extra hazardous nature of the game, the assumption that there was insurance, as well as the other factors enumerated in Section 3.

B. Regarding was there an employee-employer relationship, the Arbitrator finds as follows:

The Arbitrator finds an employee-employer relationship existed between Petitioner and Respondent. Respondents in this matter did not present any credible evidence to dispute Petitioner's employment of Petitioner. First and foremost, as recited in the foregoing Section A of the Arbitrator's Decision, Petitioner presented photographic evidence, and emails delineating the terms of his employment, including work/practice/game schedules, incentives and bonus pay. Petitioner also testified to a second email entered into evidence, welcoming him to the team, and stating employment began October 1, 2012, and that all team activities beginning on that date were mandatory. (PX 24).

In addition, this email also stated employee housing would be available as of October 1, 2012, and Petitioner testified he moved into the employee housing on that date. (PX 24).

Petitioner confirmed he lived at the residence with McKinney until Mokry cruelly evicted Petitioner shortly after his injury. Mokry did not dispute evicting Petitioner. McKinney confirmed he lived at the employee housing with Petitioner. Brisson also confirmed Petitioner lived at the house where many of the players lived. All three testified that only players on the team lived at said residence. Respondent did not provide any credible evidence to rebut said testimony or evidence. The Arbitrator gives great weight to the testimony of Petitioner and his two teammates Brisson and McKinney.

Petitioner also described in detail the tryout and hiring process, as well as where he signed the contract for employment. Both witnesses also confirmed the manner in which Mokry, the team's owner, signed players. Mokry is depicted in a photograph shaking hands with Petitioner after Petitioner signed the contract. Petitioner testified he was signing the contract. Mokry disputed it was a contract and the photo merely depicted Petitioner signing a waiver. Petitioner's witnesses both credibly confirmed, when asked to compare the documents in the picture with their own contracts, the photograph depicted Petitioner signing the contract for employment.

McKinney also testified to signing the contract corroborating and substantiating Petitioner's testimony. McKinney testified he signed many contracts in the past and also signed many waivers in his career. McKinney testified in his opinion, the photograph depicted Petitioner signing the contract for several reasons. When he viewed the photograph, in particular the similarity between the documents Petitioner was signing in the photo compared to the contract he signed, he testified it was clearly the same contract in the photo which McKinney signed. McKinney further testified in his experience, when a player signs a contract, the player dresses up, wears formal clothing, such as those depicted in the photograph of Petitioner in

Petitioner's Group Exhibit 21, because the player knows there will be photographs taken of a significant occasion, in particular if it is a player's first signing, as was the case in this instance for Petitioner. McKinney went on to testify that if it is merely a waiver being signed, it is like signing a receipt, and one would never dress up formally, nor would photos be taken with other "pretty women" as was the case in this instance. He stated one would never dress up to sign a waiver. McKinney's testimony further corroborated Petitioner's testimony he was in fact signing the actual contract for employment in Petitioner's Group Exhibit 21.

In addition to the foregoing evidence, Petitioner, Brisson, and McKinney all testified to the Twitter account photos sent by Mokry announcing the 2012-2013 Chicago Soul Roster, and introduced into evidence as Petitioner's Exhibit 22. Both testified the photo depicted many of, but not all of, the employee players of the Soul, and their coach. Mokry attempted to dispute this by stating not all of the people in the picture were actually employed by the Soul. The Arbitrator finds Mokry's testimony regarding these photos not credible, and gives no weight to his testimony or allegations regarding this evidence.

Petitioner and Brisson both testified as to the facts surrounding Petitioner's injury. Both provided the exact same testimony regarding Petitioner's accident. In particular, both credibly testified only employees/players on the team were allowed at the practice on October 3, 2012, the date of Petitioner's accident. The Arbitrator finds this testimony credible, and establishes employee-employer relationship between Petitioner and Respondent.

The Arbitrator finds Mokry's testimony and feeble attempts to discredit Petitioner not credible at best. Mokry provided inconsistent testimony as to whether he was or was not at the practice when Petitioner was injured. Mokry provided non-credible evidence as to how players were signed, and then allegedly let go or cut from the team if the team chose. Mokry also

attempted to state that one of the photos which showed Petitioner, Payal Patel, Mokry's Director of Marketing/Director of Communications, and Herrera was a photo taken because all three had gone to Marquette University together, alluding to the fact the photo was taken as a college reunion of sorts. Petitioner discredited this completely by testifying he went to at University of Wisconsin, Milwaukee. The Arbitrator finds Mokry's testimony was self-serving, dishonest, and not the least bit credible. Brisson, a veteran of the league, also discredited Mokry and credibly contradicted Mokry's testimony regarding which players were on the team. In addition the Arbitrator finds Mokry intentionally and deceptively refused to provide Petitioner with the signed contract. The Arbitrator finds this negates any of Respondent's allegations. The Arbitrator finds Petitioner was an employee of the Respondent on October 3, 2012.

C. Regarding whether an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds Petitioner presented credible testimony regarding his accident, and Petitioner's accident arose out of and the course of Petitioner's employment by Respondent. Petitioner testified on October 3, 2012, he attended the first full team practice. Petitioner testified only players who were signed to and employed by Respondent were allowed at the practice. Petitioner's witness Brisson corroborated only players actually employed by the team at that time were allowed at the practices.

Petitioner testified another much larger player jumped on his back, and he felt a snap and immediate pain in his left knee, rendering him unable to play further. Brisson corroborated Petitioner's testimony and provided the exact same description of events regarding the mechanism of Petitioner's accident and injury.

Respondent did not provide any evidence to dispute Petitioner's testimony. Respondent also did not provide any evidence to dispute Brisson's testimony confirming Petitioner's

accident. The Arbitrator finds Petitioner's and Brisson's uncontradicted testimony regarding the accident, credible, and finds Petitioner sustained an accident which arose out of and in the course of his employment with Respondent.

D. Regarding what was the date of the accident, the Arbitrator finds as follows:

The Arbitrator finds the date of accident was October 3, 2012.

E. Regarding whether timely notice of the accident given to Respondent, the Arbitrator finds as follows:

The Arbitrator finds timely notice of the accident was given to Respondent. Petitioner testified after the accident, he immediately reported to the head trainer for the team. The trainer performed a test on his knee and advised he needed to go to the team doctor as soon as possible. Petitioner testified he then called Mokry to seek medical attention. He testified Mokry repeatedly told him the team would pay for the medical treatment and surgery. Petitioner testified he continued to call Mokry to find out when he could go to the doctor, as he relied on Mokry as the team owner and the person he talked to the most on behalf of the team. Petitioner testified Mokry represented at this time and in the future continued to represent the team would pay for medical treatment and subsequently diagnosed need for surgery. He also repeatedly told Petitioner the team had insurance.

Mokry attempted to dispute he had notice of the injury. Mokry provided completely inconsistent testimony regarding notice. Mokry alleged he was at the practice attempting to differentiate who informed him of the injury and how Petitioner informed him of the injury. At first he stated he was at the practice, and Petitioner did not have to call him, and he never received this call from Petitioner. Instead, Mokry testified he was informed of the injury by Sarah the trainer, and the trainer, employed by the team then sent Petitioner to the team doctors at Midwest Bone & Joint.

The Arbitrator finds Mokry's testimony inconsequential and not credible. Regardless of how he was made aware of the injury, the Arbitrator finds Petitioner's testimony regarding the multiple phone calls made by Petitioner basically begging for Mokry to authorize medical care more than sufficient to establish notice pursuant to the Act. The Arbitrator finds Petitioner provided, and Respondent received timely notice of the accident.

F. Regarding whether Petitioner's current condition of ill-being is 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 accident. The medical records of Midwest Bone & Joint, beginning on October 8, 2012, confirm Petitioner's credible testimony regarding Petitioner's injuries. The Arbitrator finds the subsequent records of Dr. Middleton, of Wisconsin Bone & Joint, also contain an accurate and consistent history of accident and of Petitioner's left ACL tear related to the accident, the surgery, and post-surgical rehabilitation. Respondent did not present any medical evidence to dispute Petitioner's left ACL tear or condition of ill-being.

Petitioner further testified as to his current condition at the time of trial. He stated he still suffered pain in the left knee, an area of numbness, and stiffness. Even more tragically he testified he was no longer able to play the game of soccer, which he had played his entire life. He testified he attempted to return to the game professionally after he was released by Dr. Middleton on July 29, 2013, was signed to a different team, took a reduction in pay to try to continue playing, but ultimately was let go due to the lack of mobility, instability, and loss of speed required to play the game. Petitioner testified he changed occupations to teaching, and at the time of trial he was employed as a kindergarten teacher and never played the game again.

G. Regarding what were Petitioner's earnings, the Arbitrator finds as follows:

The Arbitrator finds Petitioner's average weekly was $425.90. The Arbitrator's finding is based upon Petitioner's testimony and Petitioner's Exhibit 23, the email provided to Petitioner by Respondent containing the document "Chicago Soul FC Player Salary and Bonus Agreement." This document is addressed to Sol Caceres, the Petitioner. It clearly states a monthly Salary of $1,800.00, plus a one-time payment of $200.00. The playing season and salary period were from October 1, 2012 through March 15, 2013, a period of 5 months and 15 days as evidenced on Schedule A of Petitioner's teammates' contracts entered into evidence as Petitioner's Exhibits 30 and 31. The Arbitrator finds Petitioner's work seasonal in nature. The Arbitrator finds this is the best evidence available of the seasonal nature of the payments to be made to Petitioner as Mokry deceptively and intentionally withheld providing Petitioner's contract to him. The Petitioner's monthly salary was $1,808.43, ($1,800/month plus one-time payment of $200.00 which is $8.43 prorated monthly totaling $1,808.43). Petitioner wold have earned $9,900.00 for the salary payment period plus another prorated $8.43 per week for the $200.00 one time payment. The season salary was to be $1,808.43, per month. The Arbitrator finds this calculates to an average weekly wage of $425.90 ($9,900.00 divided by 23.714 + $8.43 = $425.90), with TTD rate of $283.93, and PPD rate of $255.54.

H. Regarding What was Petitioner's age at the time of the accident, the Arbitrator finds as follows:

The Arbitrator finds Petitioner was 25 years old at the time of accident based upon Petitioner's unrebutted credible trial testimony as to his date of birth and age.

I. Regarding what was Petitioner's marital status at the time of the accident, the Arbitrator finds as follows:

The Arbitrator finds Petitioner was single at the time of the accident based upon Petitioner's unrebutted credible trial testimony.

J. Regarding whether the medical services that were provided to Petitioner reasonable and necessary, and whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator finds the medical services provided to Petitioner were reasonable, necessary, and causally related to Petitioner's work related accident. The Arbitrator finds the charges for all medical services were reasonable and necessary. The Arbitrator finds Respondent has not paid any of the reasonable, necessary, and appropriate charges for Petitioner's work related injury, and finds Respondent liable for all such charges. The Arbitrator orders Respondent to pay $1,740.00 to Ace Acupuncture Clinic, $10,094.08 to Wisconsin Bone & Joint, $2,133.93 to Glendale Anesthesia, $12,679.26 to Froedert Hospital, $2,164.39 to Froedert Hospital, $824.92 to Optimum Outcomes/ Froedert Hospital, $13,504.18 to Optimum Outcomes/ Froedert Hospital, $17,668.18 to Americollect/Orthopaedic Hospital of Wisconsin, $1,557.19 to MHFS Collection/Froedert Hospital, $2,400.96 to MHFS Collection/Froedert Hospital $2,164.39 to MHFS Collection/Froedert Hospital, and $2,655.16 to MHFS Collection/Froedert Hospital

K. Regarding what temporary total disability benefits are in dispute, the Arbitrator finds as follows:

Petitioner testified he did not return to work starting October 4, 2012, at which time the trainer told him he was unable to play. Petitioner attempted to go to the team physicians immediately, but Mokry delayed scheduling the appointment, and would not allow him to see the physicians, despite by his own admission, the team trainer and Petitioner advised Petitioner was unable to work. Petitioner finally saw the team physician, Dr. Seeds, on October 8, 2012, at which time he was immediately restricted from work, and also diagnosed with a probable ACL tear. Dr. Seeds shortly thereafter an MRI was performed, and Dr. Seeds prescribed surgery for Petitioner.

After that date, Mokry then began stalling and not authorizing treatment per Petitioner's testimony. Mokry continued to misrepresent to Petitioner there was insurance, and the team would "take care of" the surgery. Mokry then evicted Petitioner from the team home, and Petitioner testified he was forced to move to his parents' home in Milwaukee, Wisconsin. Petitioner continued to attempt to contact Mokry to obtain authorization to obtain the surgery he needed. Petitioner testified Mokry became increasingly evasive. If Petitioner was able to get through to Mokry via telephone, Mokry would lie and tell him the surgery would be authorized, and provided Petitioner with various excuses as to why he had not been able to obtain surgery or why he had not provided authorization. The Arbitrator finds Petitioner's testimony particularly persuasive and credible over the testimony of Mokry. Petitioner testified his parents eventually added him to their personal insurance and he sought care of Dr. Middleton at Wisconsin Bone & Joint. Petitioner then resumed care with Dr. Middleton in Milwaukee, who continued to restrict him from work through July 29, 2013, at which time he was released only because Petitioner's parents insurance would no longer cover his medical care. Petitioner testified he was off work and did not receive any pay from any source from October 4, 2012, through July 29, 2013, a period of 42 and 5/7ths weeks.

Mokry attempted to dispute Petitioner's testimony, both by cross examining Petitioner and providing his own testimony. Mokry attempted to state he "thought" the team had insurance because he paid an amount to someone at a team/league meeting in Florida. He further alleged he paid $15,000.00 to Midwest Bone & Joint, which he "thought" would cover the injuries sustained by Petitioner or other players. Mokry provided no proof of any such payments having been made. Mokry also attempted to state Petitioner had been injured prior to joining the team and being hired as a player. Mokry provided no evidence at all regarding this, and the allegation

was also refuted by both Petitioner and Brisson, who both credibly and persuasively testified Petitioner was perfectly healthy on the date of accident. Once again, Mokry offered nothing more than self-serving allegations, replete with inconsistencies and misrepresentations. The Arbitrator again finds Mokry's testimony not the least bit credible. No evidence was provided by any party to dispute Petitioners period of incapacity. The Arbitrator finds Petitioner's testimony extremely credible.

The Arbitrator finds Petitioner's period of incapacity began on October 4, 2012, based on Petitioner's testimony regarding his inability to play, the delay Mokry created in authorizing treatment, and the team trainer advising him that he could not play. In addition the medical records of Midwest Bone & Joint, and Dr. Middleton/Wisconsin Bone & Joint support Petitioner's period of temporary total disability. The Arbitrator finds Petitioner entitled to TTD benefits for 42 and 5/7ths weeks covering the period of October 4, 2012, through July 29, 2013. Based on Petitioner's TTD rate of $283.93 the Arbitrator finds Petitioner entitled to $12,127.87 ($283.93 x 42.714 = $12,127.87).

L. Regarding what is the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator finds Petitioner sustained a permanent injury to his left leg. The Arbitrator specifically notes Petitioner was only 25 years old at the time of accident, and it was his first time playing soccer professionally. Petitioner was a rookie at the time and believed this was the start of a long professional career. Petitioner testified despite briefly attempting to return to the game for another team, he was unable to play and was released from that team. Petitioner provided credible, uncontradicted trial testimony that his left knee was still quite painful, he had numbness in the knee, and it was constantly stiff, all of which he never experienced prior to the accident. The Arbitrator finds Petitioner was no longer able to pursue his occupation as a

professional soccer player, and Petitioner testified he had to switch occupations and began teaching kindergarten. The Arbitrator finds Petitioner entitled to 45% loss of use person as a whole, and orders Respondent to pay $57,586.50 ($255.94 rate x 225 = $57,586.50) due to loss of trade pursuant to Section 8(d)(2) of the Act.

N. Regarding whether Respondent due any credit, the Arbitrator finds as follows:

The Arbitrator finds Respondent is not due any credit.

O. Regarding other issues in dispute, including notice to employer; insurance; all issues in dispute, the Arbitrator finds as follows:

Counsel for the Injured Workers' Benefit Fund listed notice to employer, insurance and all issues in dispute on the Request for Hearing form submitted at trial. In relation to notice, it is unclear whether the IWBF's counsel was alleging notice of accident to Respondent, or notice of the trial proceedings. For the reasons set forth in Section E of this decision, the Arbitrator finds Petitioner properly provided notice to Respondent of the accident.

The Arbitrator additionally finds Petitioner provided notice of the March 10, 2020 hearing date to the Respondent, and complied with Section 7030.2o(c)(1) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission. The Petitioner served on all parties, and the registered agent for Respondent trial letters proper Notice of Motions and introduced into evidence as Petitioner's Exhibits 25, 26, 27, 28, 29. The Arbitrator also finds notice of the hearing was properly served on all parties as neither Counsel for the IWBF nor Mokry objected to the admission of these exhibits either. The Arbitrator also finds notice was proper as Respondent Mokry, the team's owner was present on his own behalf, and on behalf of Chicago Soul, and Respondent Mokry was present at several prior trial dates, and provided notice personally on said dates.

The Arbitrator finds Respondent did not have insurance. The Arbitrator finds Respondent Mokry's actions and excuses in regard to not obtaining insurance not credible. Mokry admitted in his testimony he did not actually have insurance despite his continued deceptive, injurious misrepresentations to Petitioner, the other players on the team, and the medical providers. Mokry is in violation of Sections 3 & 4 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Arbitrator Kurt Carlson

06-15-20

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC036852
Case Name	JOHNSON, RUBY v. PAIGE BUS ENTERPRISES INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0434
Number of Pages of Decision	17
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Michael Trybalski
Respondent Attorney	Bonnie B. Bijak

DATE FILED: 8/24/2021

/s/Stephen Mathis,Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUBY JOHNSON,

Petitioner,

vs. Nos: 16 WC 36852

PAIGE BUS ENTERPRISES, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator with respect to the issue of the permanent partial disability (PPD) benefit rate. The Arbitrator ordered Respondent to pay PPD benefits of $220.00 per week for 20 weeks due to the injuries sustained by Petitioner, representing a 4% loss of the person-as-a-whole. Respondent argues that the $220.00 rate is incorrect because the parties had stipulated that Petitioner's average weekly wage (AWW) at the time of the accident was $208.76. Petitioner agrees that any awarded PPD benefits "should have been calculated at the correct, and stipulated PPD rate of $208.76," characterizing the figure as a "simple clerical error."

In this case, the Arbitrator awarded $220.00 per week, representing the minimum PPD rate for an injury to a single person on November 30, 2016. However, the parties are correct in determining that the Arbitrator should have awarded at the rate of Petitioner's AWW of $208.76. See 820 ILCS 305/8(b)(2.1) (West 2016). Accordingly, the Commission modifies the Arbitrator's PPD award to reflect a benefit rate of $208.76 per week.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated September 6, 2019 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $208.76 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 4% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $13,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 24, 2021

o: 8/19/21
SJM/kcb
044

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

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, RUBY
Employee/Petitioner

Case# **16WC036852**

PAIGE BUS ENTERPRISES INC
Employer/Respondent

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

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

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

5094 SKLARE LAW GROUP LTD
MICHAEL R TRYBALSKI
20 N CLARK ST SUITE 1450
CHICAGO, IL 60602

1739 STONE & JOHNSON CHARTERED
BONNIE BIJAK
111 W WASHINGTON ST SUITE 1800
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

Ruby Johnson
Employee/Petitioner

v.

Paige Bus Enterprises, Inc.
Employer/Respondent

Case # **16** WC **36852**

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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **August 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 30, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**2,505.07**; the average weekly wage was $**208.76**.

On the date of accident, Petitioner was **83** 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 $**1,401.66** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,401.66**.

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

ORDER

Respondent shall pay fees and charges for reasonable and necessary medical care as follows: Village of Posen Fire Department $125.00, advanced physical medicine $6,653.54, and Archer Open MRI $1950.00, in accord with §8(a) of the Act and adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Respondent shall pay Petitioner Temporary Total Disability benefits of **$208.76/week** for **7 & 3/7 weeks**, commencing **December 2, 2016** through **January 22, 2017**, less a credit of $1,401.66 for Respondent's prior payment of TTD benefits, as provided in §8(b) of the Act.

Respondent shall pay Petitioner $220.00/week for 20 weeks due to the injuries sustained by petitioner which caused permanent partial disability of **4% loss of a person-as-a-whole**, pursuant to §8(d)2 of the Act.

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

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

Signature of Arbitrator

September 5, 2019
Date

SEP 6 - 2019

Ruby Johnson v. Paige Bus Enterprises, Inc.,
16 WC 36852

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:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

FINDINGS OF FACT

Petitioner Ruby Johnson was employed by Respondent Paige Bus Enterprises, LLC on November 30, 2016. Petitioner began her employment with Respondent in August 2016. Petitioner was employed as a bus monitor. Petitioner did not drive buses or other vehicles. Petitioner retired from the U.S. Postal Service in October 1992. She had worked as a bus driver with other companies after retiring. She retired from driving because of her advanced age and concern for safety before the date of her accident.

On November 30, 2016 Petitioner was the only passenger in Respondent's bus when there was a collision between the bus and a passenger car. She was seated directly behind the driver. The bus was returning to Respondent's terminal after completing the morning route. The collision occurred when the bus started up for a right turn from a stop and struck the rear of the car in front.

Petitioner stated that she did not feel any pain during the collision itself. She testified further that she was however "shaken up" by the incident. Petitioner testified that she did not call 911, but that an ambulance responded. Petitioner declined emergency transport/treatment. She did observe damage to the other vehicle involved in the collision. According to Petitioner, the rear end of the other vehicle was "crushed in." Petitioner stated that the bus looked "okay." The Posen (IL) report EMS noted refusal of care and minor damage on the bus (PX #1).

Petitioner testified that the following morning, she woke up feeling of stiff and sore "all over." She went into work and told her manager she needed to see a doctor her manager referred her to South Suburban Hospital where she was seen at Advocate Occupational Health (PX #3).

Petitioner testified that she was not experiencing any pain or problems in her lower back on or immediately prior to the incident of November 30. She acknowledged a prior work-related injury. Specifically, Petitioner testified that she had filed and settled prior Workers' Compensation claims involving an April 2000 "man-as-a-whole" injury, a December 2010 right foot injury, and a March 2014 back and knee/leg injury.

At Advocate Petitioner complained that her back hurt down into her legs. She stated that it felt like someone "sprinkled pepper" on her legs. On examination she had pain to palpation over the right and left sacroiliac joints. Petitioner had near-complete back range of motion but with discomfort. She was diagnosed with low back pain and taken off work until follow up on December 5, 2016.

On December 2, 2016 Petitioner sought care at Advanced Physical Medicine where she was seen by Dr. Aleksandr Goldvekht (PX #5). Petitioner gave a history of her accident on November 30 which caused her torso to be thrown forward and backward. She complained of severe low back pain and pain in the hamstrings since then. She reported that she could not sit for long periods of time due to discomfort. On examination Petitioner had mild antalgic gait and moderately decreased but painful lumbar motion. There was moderate hypertonicity in the lumbar paraspinals and the quadratus lumborum muscle.

Petitioner testified that she was referred to Advocate by attorney Barry Rabovsky. She had requested a referral from this attorney, and that the only doctor she knew was a primary care physician. Dr. Goldvekht noted trigger points in the lower paraspinal muscles, SI joints, bilateral posterior thighs, and the gluteus maximus. Straight-leg raise was negative, but Kemp's test was positive. Dr. Goldvekht diagnosed lumbar disc without myelopathy and bilateral hamstring injury. Terocin pain patches were administered to avoid the addictive quality of pain medication. Dr. Goldvekht ordered physical therapy and follow up to five weeks. Petitioner was to remain off work until her follow-up.

Petitioner returned to Dr. Goldvehkt January 4, 2017 with complaints of 6/10 pain. Petitioner's clinical presentation was unchanged as was the doctors diagnoses. Dr. Goldvehkt continued Terocin patches and physical therapy. He ordered a lumbar MRI. He kept Petitioner off work until her follow-up in 4 weeks.

The lumbar MRI at Archer Open MRI on January 13, 2017 demonstrated spondylotic changes, facet arthropathy, and disc bulging causing stenosis at L4–5 and L5–S1 (PX #7),

On January 18, 2017 Petitioner's condition was essentially unchanged. Dr. Goldvehkt continued physical therapy and the Terrace in pain patches. Petitioner was referred for interventional pain management. Petitioner was released to return to work beginning January 23 with 5-pound lifting, carrying, and pushing/pulling restrictions.

Petitioner saw Dr. Scott Glaser January 23, 2017. She complained of neck and upper extremity pain, left greater than right lower back pain, and bilateral lower extremity radicular pain. She complained of 7-10/10 pain. Dr. Glaser found a total disability score of 94/100. Dr. Glaser administered bilateral transforaminal epidural steroid injections L4–5 and L5–S1.

On February 15, 2017 Petitioner saw Dr. Goldvehkt again. Her clinical presentation was unchanged. He continued the Terocin pain patches and ordered an FCE. Petitioner was to continue light duty work restrictions for the next week.

The February 20, 2017 FCE found Petitioner in the light strength category, which met the occupational requirements of school bus monitor, and found that she could return to work.

Petitioner returned to Dr. Goldvehkt February 22, 2017. She still had lower back and hamstring pain. Lumbar range of motion was moderately decreased and painful. She still had tender trigger points and moderate hypertonicity. Dr. Goldvehkt found Petitioner at MMI and released her to return to work with the FCE restrictions: no pushing/pulling more than 10 pounds, no stooping, no kneeling, occasional lifting and carrying 10 pounds.

Petitioner underwent a total of 20 sessions of physical therapy between December 9, 2016 and February 21, 2017.

Evidence deposition of Dr. Julie Wehner, October 12, 2017 (RX #3)

Petitioner was examined by board-certified orthopedic surgeon Dr. Julie Wehner on January 9, 2017 at Respondent's request pursuant to §12 of the Act. Dr. Wehner is also board-certified by the American Board of Independent Medical Examiners. The transcript of her October 12, 2017 evidence deposition was admitted at trial by Respondent. Dr. Wehner refreshed her memory from the narrative report she prepared form her IME of Petitioner. The report was admitted without objection.

In addition to performing a clinical examination of Petitioner Dr. Wehner reviewed Petitioner's records from Advocate Occupational Health note from December 1, 2016 and Advanced Physical Medicine note from December 2, 2016. She also had an Employee Injury Report dated December 2, 2016. Dr. Wehner did not review Petitioner's physical therapy notes or the MRI imaging of Petitioner's lumbar spine or the radiologist's report. Dr. Wehner admitted that she did not obtain any of her own imaging, nor did she request any imaging from Respondent or Respondent's attorney.

Petitioner gave a history of the accident and her physical complaints of neck pain radiating to her left shoulder and going down the back along with back pain radiating down the back of legs. She did see her primary care physician Dr. Daniel Yaho, who told her to stay off work. She told Dr. Wehner that she had had physical therapy and an injection. Petitioner also reported that her primary care physician is Dr. Dinesh Jain. She reported that she was taking Xanax, Metoprolol, Synthroid, Coumadin, Tylenol, Vitamin C, and Zyrtec.

Petitioner recited a history of a right knee injury in 2010 and also in 2014. She was hospitalized in 2016 Ingalls Memorial Hospital or a suspected stroke. She was put on blood thinners at the time.

On examination Petitioner had mild pain to light palpation over the left SI joint, moderate pain on axial compression but no pain on axial rotation. Petitioner could bend and touch her toes. Straight-leg raise was negative. Hip motion was without pain. Sensation to light touch was intact and motor strength was 5/5.

Dr. Wehner described the vehicle impact as being "minor." On cross-examination Dr. Wehner admitted that she did not know whether either of the drivers was injured, if any damage done to the bus or the other vehicle during the impact, whether Petitioner was seat-belted or otherwise restrained at the time of impact, or how fast the vehicles were going at the time of impact.

Dr. Wehner opined that Petitioner had sustained "at most a minor sprain to the back" as a result of the November 30, 2016 motor vehicle accident. In her opinion, this was the type of injury that resolves without any medical intervention and which would heal in an uneventful fashion. Dr. Wehner further opined that the care at Advocate Occupational Health was reasonable and necessary, but that there was no medical indication for the Petitioner to use creams on her back or any indication to recommend narcotic medication. Dr. Wehner further opined that due to the soft tissue nature of the injury, and the minimal impact accident, that there was no need to perform any form of therapy, either chiropractic or otherwise. There was no indication to perform therapy or diagnostic testing or a possible mild strain. She opined that the Petitioner should have

been at MMI within 2 weeks of the incident and was capable of returning to work as a bus monitor.

Dr. Wehner acknowledged that it may take longer for an 84-year-old woman to recover from injuries than it would take someone younger/in better health to recover from.

Dr. Wehner also noted her familiarity with one of Petitioner's treating doctors, adding that it didn't surprise her that Dr. Goldvehkt's ordered a lumbar MRI quickly, but adding "that isn't the way real medicine works."

On further cross-examination Dr. Wehner acknowledged that the MRI and physical therapy had taken place after her IME on January 9, 2017 and that he could not have reviewed those records. She did not receive or review physical therapy and MRI records after the IME.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that her current condition of ill being is causally related to her work accident on November 30, 2016.

Petitioner was involved in what by some accounts a minor motor vehicle collision. However, the Arbitrator notes that Petitioner was 83 years of age at the time of the occurrence. Further, Petitioner's MRI demonstrated degenerative changes associated with that advanced age. Although none of the physicians involved in Petitioner's care or IME found or opined that petitioner sustained an exacerbation of a pre-existing condition, the evidence strongly suggests that Petitioner did in fact sustain an exacerbation of a pre-existing degenerative condition in her lumbar spine.

Petitioner declined intervention by EMTs who responded to the scene of the occurrence. However, she testified credibly that the next day she felt pain all over. She was seen at Advocate occupational health at South Suburban Hospital that following day, December 1. At her IME with Dr. Wehner petitioner reported that she had consulted her primary care physician, Dr. Yaho, that same day, December 1. The fact that petitioner did not testify to Dr. Yoho's consultation or submit the records of that consultation does not detract from the apparent fact that petitioner sustained an exacerbation of a pre-existing degenerative condition.

Petitioner did seek care from Advanced Physical Medicine on December 2, 2016, on referral from attorney Barry Rabovsky. An attorney's referral of his client to a physician does not detract from the legitimacy of a claim of injury where, as here, there is credible testimony of pain, discomfort, and injury. An attorney's referral does not necessarily subvert a claim of the injury for which medical intervention may be necessary.

Respondent's IME physician, Dr. Julie Wehner, disputed the reasonableness and necessity of Petitioner's medical care from Advanced Physical Medicine. Dr. Wehner based her opinions on her clinical IME of Petitioner and only two clinical notes, the last of which was December 2, 2016. Dr. Wehner's opinions are based on an embarrassing paucity of medical evidence. Granted, Dr. Wehner's IME was conducted before Petitioner finished her medical care and physical therapy. However, Dr. Wehner did not supplement her opinions with a review of Petitioner's entire course of medical care and physical therapy. The Arbitrator does not find Dr. Wehner's opinions persuasive due to an incomplete review of Petitioner's entire course of medical care and physical therapy. Dr. Wehner cannot be heard to say that medical intervention is unnecessary without a full and complete review of that care

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

The Arbitrator finds that Petitioner proved that she received necessary and reasonable medical care for the injuries she sustained in her work accident on November 30, 2016.

Respondent does not seem to dispute the reasonableness and necessity of petitioner's initial medical visit on December 1, 2016 at Advocate Occupational Health. Respondent does dispute that the medical care and physical therapy Petitioner received at advanced physical medicine was reasonable and necessary to cure or relieve the injuries she sustained in her work accident. Respondent supports this position with the opinions of its IME physician, Dr. Julie Wehner.

The Arbitrator previously found Dr. Wehner's opinions to be unpersuasive. Dr. Wehner reviewed only 2 clinical medical notes, the last being December 2, 2016. As stated above Dr. Weiner cannot credibly opine that medical care or physical therapy is not medically necessary without having reviewed the entire record of the purported unnecessary care.

Failing a credible rebuttal, again, the Arbitrator finds that Petitioner proved that she received necessary and reasonable medical care for the injuries she sustained in her

work accident. Likewise, for failure of credible rebuttal, the Arbitrator finds that the medical fees and bills for medical care provided to Petitioner was reasonable and necessary.

Petitioner submitted medical bills and corresponding records at the time of trial. In total, Petitioner incurred $8,906.54 in medical charges/bills in connection with her injuries. Those charges are outlined in Petitioner's Exhibits #2 (Posen fire Department for $125.00), #4 (Advocate Occupational Health for $178.00), #6 (Advanced Physical Medicine for $6,170.54), and #8 (Archer Open MRI for $1,950.00).

By the time of trial, Respondent had paid only Advocate Occupational Health for the $178.00. Respondent has not paid the remaining $8,728.54 in fees and charges for Petitioner's reasonable and necessary medical care. The Arbitrator finds that Respondent shall pay to Petitioner $8,728.54, the total of medical fees and charges outlined in Petitioner's Exhibits #2, #4, #6, and #8, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

K: What temporary benefits are in dispute? TTD

The Arbitrator finds that Petitioner proved that she is entitled to Total Temporary Disability benefits from December 2, 2016 through January 22, 2017, 7 & 3/7 weeks.

The Arbitrator previously found that Petitioner's condition of ill-being was causally related to her accidental work injury. The Arbitrator also found that Petitioner proved that her medical care was reasonable and necessary. Petitioner's treating physicians kept her off work until she had, according to Dr. Goldvehkt, reached MMI on January 22, 2017. Dr. Goldvehkt released Petitioner to return to work with the FCE restrictions.

Respondent's IME physician, Dr. Wehner, found Petitioner at MMI January 9, 2017, the date of the IME. For reasons set forth above, the Arbitrator does not find Dr. Wehner's opinion regarding Petitioner's MMI to be persuasive.

Respondent shall be given a credit for those $1,401.66 in TTD benefits issued prior to trial.

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

The Arbitrator evaluated Petitioner's Permanent Partial Disability in accord with §8.1b of the Act.

i) No AMA Impairment Rating was admitted in evidence. The Arbitrator could not give any weight to this factor.

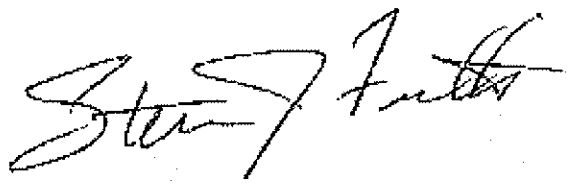
ii) Petitioner was employed as a Bus Monitor at the time of the accident. The job did not require strenuous or heavy work. She was able to return to this work with restrictions. The Arbitrator gives moderate weight to this factor.

iii) Petitioner was 83 years old at the time of the accident. She had a statistical life expectancy of approximately 8 years. Due of Petitioner's advanced age and inherently slower recovery time, Petitioner is likely to endure the effects of her injury more painfully with greater limitations to activities of daily living. The Arbitrator gives great weight to this factor.

iv) Petitioner was released to return to work with restrictions. Respondent did not accommodate those restrictions. Nonetheless, The Arbitrator notes the statistical worklife expectancy was zero. The Arbitrator gives no weight to this factor.

v) Petitioner's medical; records demonstrated that Petitioner sustained an aggravation of degenerative conditions in her spine. The injury required medical intervention, including physician consultations, physical therapy, radiological imaging, transforaminal ESIs, and an FCE. Petitioner di reach MMI but was unable to return to her former job. The Arbitrator gives great weight to this factor.

Based on the above factors, and the evidence taken as a whole, the Arbitrator finds that Petitioner sustained Permanent Partial Disability to the extent of 4% loss of use of the person-as-a-whole, 20 weeks, pursuant to §8(d)2 of the Act.



Steven J. Fruth

September 5, 2019
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC009792
Case Name	LISAK, CELESTE v. CITY OF CHICAGO-FLEET MGMT
Consolidated Cases	12WC011061
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0435
Number of Pages of Decision	11
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Stephen Cummings
Respondent Attorney	Stephanie Lipman

DATE FILED: 8/24/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Celeste Lisak,
Petitioner,

vs.

No. 15 WC 009792
(consolidated with 12 WC 011061)

City of Chicago—Fleet Management,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of clerical error and nature and extent of permanent disability, and being advised of the facts and law, corrects the clerical error in 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 nature and extent of Petitioner's injury, the Arbitrator found that the injuries sustained caused a 10% loss of use of the person-as-a-whole. However, his Order awarded 75 weeks. The Commission finds that this was a clerical error and modifies the Decision to reflect the proper number of weeks for the award, 50 weeks. 820 ILCS 305 §8(d)2.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2020 is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner $461.70 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused 10% disability of the person-as-a-whole.

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 $23,200.00.The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 24, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-8/19/21
068

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

/s/ *Stephen Mathis*
Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LISAK, CELESTE
Employee/Petitioner

Case# **15WC009792**

12WC011061

CITY OF CHICAGO - FLEET MGMT
Employer/Respondent

On 4/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4642 O'CONNOR & NAKOS
STEPHEN CUMMINGS
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CELESTE LISAK
Employee/Petitioner

v.

CITY OF CHICAG0 - FLEET MGMT.
Employer/Respondent

Case # **15** WC **09792**

Consolidated cases: **12 WC 11061**

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 **Arbitrator Charlie Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **June 11, 2019**. By stipulation, the parties agree:

On the date of accident, **March 3, 2015**, 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 $**43,235.45**, and the average weekly wage was $**831.45**.

At the time of injury, Petitioner was **76** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**22,014.82** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,014.82**.

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

ORDER

Respondent shall pay Petitioner the sum of $**498.87**/week for a further period of **75** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **permanent partial disability to the extent of 10% loss of a person as a whole..**

Respondent shall pay Petitioner compensation that has accrued from **March, 3, 2015** through **June 11, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 27, 2020
Date

APR 3 - 2020

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

CELESTE LISAK,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO. 15 WC 09792
	)	(Consolidated with 12 WC 11061)
	)	
CITY OF CHICAGO – FLEET MGMT.	)	
	)	Arbitrator Charlie Watts
Respondents.	)	

I. STATEMENT OF FACTS

The parties have stipulated that on March 3, 2015, Celeste Lisak, hereinafter referred to as Petitioner was employed by the City of Chicago, hereinafter referred to as Respondent. The parties further stipulated that on that date, Petitioner was involved in an accident arising out of and in the course of her employment. Further, the parties have stipulated that proper notice of this accident was given and Petitioner's current condition is causally related to the accident. Further, the parties have stipulated that Petitioner's earnings in the year preceding the injury were $43,235.45 and her average weekly wage was $831.45. Further, the parties have stipulated that at the time of her accident Petitioner was 76 years old, single with zero dependent children. The parties have further stipulated that Respondent has paid the reasonable, necessary medical associated with this injury. (Arbitrator's Exhibit No. 2)

In addition, the parties have stipulated that Petitioner was temporary and totally disabled from work from March 7, 2015 through December 9, 2015 representing 39 4/7 weeks. The parties have also stipulated that Respondent has paid $22,014.82 in temporary total disability. The only issue in dispute is the nature and extent of Petitioner's injuries. (Arbitrator's Exhibit No. 2)

On March 3, 2015, Petitioner was employed as a Watchman, for the Respondent. On that date, Petitioner attempted to close a 12-foot gate that was stuck due to the cold weather. While trying to

forcibly close the gate, Petitioner felt the immediate on-set of severe pain in her neck and left shoulder. Petitioner's testimony in this regard is unrebutted and corroborated by the medical histories contained in the treating medical records.

Petitioner began treatment for these injuries on March 6, 2015. Petitioner's treating physicians ultimately diagnosed her with a large full thickness tear of the left rotator cuff as well as cervical spondylosis. Petitioner treated for these conditions non-surgically from March 6, 2015 until October 1, 2015.

During the course of her care and treatment, Petitioner underwent a Functional Capacity Evaluation on September 22, 2015 at U.S. Healthworks Medical Group. Petitioner was released back to work with permanent restrictions as delineated by the Functional Capacity Evaluation. (Petitioner's Exhibit #5 pgs. 216-236) .Respondent was able to take Petitioner back to work as a Watchman while accommodating the permanent restrictions.

Petitioner was taken off-work by her treating doctors from March 7, 2015 through December 9, 2015, the date Respondents took Petitioner back to work as a Watchman within her permanent restrictions. During that time, Respondents paid Petitioner her workers' compensation benefits.

Petitioner's unrebutted testimony is that prior to March 7, 2015, she had never injured her left shoulder or neck. Petitioner further testified that she had never previously sought any medical treatment whatsoever relative to her left shoulder and neck prior to March 3, 2015. In addition, Petitioner testified that she has suffered no new injuries to her left shoulder and neck since March 3, 2015. Petitioner's testimony is unrebutted.

Petitioner further testified that upon returning to work on December 9, 2015 as a Watchman for Respondents, she noted continued pain in her left shoulder and neck associated with increased activities

and lifting at work. Petitioner further testified that she notes increased pain in her left shoulder and neck with increased activity of daily living. Petitioner's testimony in this regard is unrebutted.

II. EXPERT OPINIONS

DR. JEFFREY COE

Dr. Jeffrey Coe drafted a Narrative Report on January 19, 2016 rendering opinions relative to the injuries Petitioner suffered on March 3, 2015. In his report, Dr. Coe opined that Petitioner was involved in an accident arising out of her employment on March 3, 2015. Dr. Coe specifically opined "Based on the findings of this examination, it is my opinion that there is a causal relationship between the injuries suffered by Ms. Lisak at work for the City of Chicago....on March 3, 2015 (left upper extremity) and her current upper extremity...symptoms and state of impairment. In my opinion, Ms. Lisak's injuries at work for the City of Chicago....on March 3, 2015 (left upper extremity) have caused permanent disability to both arms and to the person as a whole (Petitioner's Exhibit No. 8)

III. FINDINGS

F). WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator adopts his findings of fact and law contained in the Statement of Facts, and incorporates them herein by this reference.

The unrefuted medical evidence clearly demonstrates that Petitioner has been diagnosed with a full thickness rotator cuff tear in her left shoulder as well as the aggravation of cervical spondylosis in her cervical spine. Both conditions were treated non-surgically. The parties have previously stipulated that these conditions are causally related to her accident at work on March 3, 2015. In addition, Petitioner's unrebutted testimony clearly demonstrates that she continues to experience significant

symptoms with respect to her left shoulder and cervical spine. Finally, Dr. Coe opined that Petitioner's injuries have resulted in permanent partial disability (Petitioner's Exhibit No. 8)

Based upon the above, the Arbitrator finds that Petitioner's injuries to her left shoulder and cervical spine cause her to be permanently and partially disabled to the extent of 10% loss of use of the person as a whole.

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CELESTE LISAK,
Petitioner,

vs.

No. 15 WC 009792
IWCC: 21IWCC0435

CITY OF CHICAGO—FLEET MANAGEMENT,
Respondent.

ORDER

The Commission finds that a clerical error exists in its Decision and Opinion on Review dated August 24, 2021, in the above-captioned matter, and on its own motion, pursuant to Section 19(f) of the Act, vacates and recalls that Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review in the above-captioned matter, dated August 24, 2021, is hereby vacated and recalled pursuant to Section 19(f) for correction of a clerical error contained therein.

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

August 25, 2021

/s/ *Marc Parker*
Marc Parker

mp/dk
68

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Celeste Lisak,
Petitioner,

vs.

No. 15 WC 009792
(consolidated with 12 WC 011061)

City of Chicago—Fleet Management,
Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of clerical error and nature and extent of permanent disability, and being advised of the facts and law, corrects the clerical error in 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 nature and extent of Petitioner's injury, the Arbitrator found that the injuries sustained caused a 10% loss of use of the person-as-a-whole. However, his Order awarded 75 weeks. The Commission finds that this was a clerical error and modifies the Decision to reflect the proper number of weeks for the award, 50 weeks. 820 ILCS 305 §8(d)2.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2020 is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner $498.87 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused 10% disability of the person-as-a-whole.

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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 25, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-8/19/21
068

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

/s/ *Stephen Mathis*
Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LISAK, CELESTE
Employee/Petitioner

Case# **15WC009792**

12WC011061

CITY OF CHICAGO - FLEET MGMT
Employer/Respondent

On 4/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4642 O'CONNOR & NAKOS
STEPHEN CUMMINGS
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CELESTE LISAK
Employee/Petitioner

v.

CITY OF CHICAG0 - FLEET MGMT.
Employer/Respondent

Case # **15** WC **09792**

Consolidated cases: **12 WC 11061**

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 **Arbitrator Charlie Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **June 11, 2019**. By stipulation, the parties agree:

On the date of accident, **March 3, 2015**, 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 $**43,235.45**, and the average weekly wage was $**831.45**.

At the time of injury, Petitioner was **76** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**22,014.82** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,014.82**.

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

ORDER

Respondent shall pay Petitioner the sum of $**498.87**/week for a further period of **75** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **permanent partial disability to the extent of 10% loss of a person as a whole..**

Respondent shall pay Petitioner compensation that has accrued from **March, 3, 2015** through **June 11, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 27, 2020
Date

APR 3 - 2020

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

CELESTE LISAK,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO. 15 WC 09792
	)	(Consolidated with 12 WC 11061)
	)	
CITY OF CHICAGO – FLEET MGMT.	)	
	)	Arbitrator Charlie Watts
Respondents.	)	

I. STATEMENT OF FACTS

The parties have stipulated that on March 3, 2015, Celeste Lisak, hereinafter referred to as Petitioner was employed by the City of Chicago, hereinafter referred to as Respondent. The parties further stipulated that on that date, Petitioner was involved in an accident arising out of and in the course of her employment. Further, the parties have stipulated that proper notice of this accident was given and Petitioner's current condition is causally related to the accident. Further, the parties have stipulated that Petitioner's earnings in the year preceding the injury were $43,235.45 and her average weekly wage was $831.45. Further, the parties have stipulated that at the time of her accident Petitioner was 76 years old, single with zero dependent children. The parties have further stipulated that Respondent has paid the reasonable, necessary medical associated with this injury. (Arbitrator's Exhibit No. 2)

In addition, the parties have stipulated that Petitioner was temporary and totally disabled from work from March 7, 2015 through December 9, 2015 representing 39 4/7 weeks. The parties have also stipulated that Respondent has paid $22,014.82 in temporary total disability. The only issue in dispute is the nature and extent of Petitioner's injuries. (Arbitrator's Exhibit No. 2)

On March 3, 2015, Petitioner was employed as a Watchman, for the Respondent. On that date, Petitioner attempted to close a 12-foot gate that was stuck due to the cold weather. While trying to

forcibly close the gate, Petitioner felt the immediate on-set of severe pain in her neck and left shoulder. Petitioner's testimony in this regard is unrebutted and corroborated by the medical histories contained in the treating medical records.

Petitioner began treatment for these injuries on March 6, 2015. Petitioner's treating physicians ultimately diagnosed her with a large full thickness tear of the left rotator cuff as well as cervical spondylosis. Petitioner treated for these conditions non-surgically from March 6, 2015 until October 1, 2015.

During the course of her care and treatment, Petitioner underwent a Functional Capacity Evaluation on September 22, 2015 at U.S. Healthworks Medical Group. Petitioner was released back to work with permanent restrictions as delineated by the Functional Capacity Evaluation. (Petitioner's Exhibit #5 pgs. 216-236) .Respondent was able to take Petitioner back to work as a Watchman while accommodating the permanent restrictions.

Petitioner was taken off-work by her treating doctors from March 7, 2015 through December 9, 2015, the date Respondents took Petitioner back to work as a Watchman within her permanent restrictions. During that time, Respondents paid Petitioner her workers' compensation benefits.

Petitioner's unrebutted testimony is that prior to March 7, 2015, she had never injured her left shoulder or neck. Petitioner further testified that she had never previously sought any medical treatment whatsoever relative to her left shoulder and neck prior to March 3, 2015. In addition, Petitioner testified that she has suffered no new injuries to her left shoulder and neck since March 3, 2015. Petitioner's testimony is unrebutted.

Petitioner further testified that upon returning to work on December 9, 2015 as a Watchman for Respondents, she noted continued pain in her left shoulder and neck associated with increased activities

and lifting at work. Petitioner further testified that she notes increased pain in her left shoulder and neck with increased activity of daily living. Petitioner's testimony in this regard is unrebutted.

II. EXPERT OPINIONS

DR. JEFFREY COE

Dr. Jeffrey Coe drafted a Narrative Report on January 19, 2016 rendering opinions relative to the injuries Petitioner suffered on March 3, 2015. In his report, Dr. Coe opined that Petitioner was involved in an accident arising out of her employment on March 3, 2015. Dr. Coe specifically opined "Based on the findings of this examination, it is my opinion that there is a causal relationship between the injuries suffered by Ms. Lisak at work for the City of Chicago....on March 3, 2015 (left upper extremity) and her current upper extremity...symptoms and state of impairment. In my opinion, Ms. Lisak's injuries at work for the City of Chicago....on March 3, 2015 (left upper extremity) have caused permanent disability to both arms and to the person as a whole (Petitioner's Exhibit No. 8)

III. FINDINGS

F). WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator adopts his findings of fact and law contained in the Statement of Facts, and incorporates them herein by this reference.

The unrefuted medical evidence clearly demonstrates that Petitioner has been diagnosed with a full thickness rotator cuff tear in her left shoulder as well as the aggravation of cervical spondylosis in her cervical spine. Both conditions were treated non-surgically. The parties have previously stipulated that these conditions are causally related to her accident at work on March 3, 2015. In addition, Petitioner's unrebutted testimony clearly demonstrates that she continues to experience significant

symptoms with respect to her left shoulder and cervical spine. Finally, Dr. Coe opined that Petitioner's injuries have resulted in permanent partial disability (Petitioner's Exhibit No. 8)

Based upon the above, the Arbitrator finds that Petitioner's injuries to her left shoulder and cervical spine cause her to be permanently and partially disabled to the extent of 10% loss of use of the person as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC011061
Case Name	LISAK, CELESTE v. CITY OF CHICAGO DEPT OF FLEET & FACILITIES
Consolidated Cases	15WC009792
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0436
Number of Pages of Decision	13
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Stephen Cummings
Respondent Attorney	Stephanie Lipman

DATE FILED: 8/24/2021

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Celeste Lisak,
Petitioner,

vs.

No. 12 WC 11061
(consolidated with 15 WC 009792)

City of Chicago—Fleet Management,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of clerical error and nature and extent of permanent disability, 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 nature and extent of Petitioner's leg injuries, the Arbitrator found that the injuries sustained caused a 7.5% loss of use of each leg. However, his Order awarded only 10.75 weeks for each leg. The Commission finds that this was a clerical error and modifies the Decision to reflect the proper number of weeks for each leg, 16.125 weeks. 820 ILCS 305 §8(e)12.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2020 is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner $461.70 per week for a period of 150.15 weeks, as provided in §8(d)2 and §8(e) of the Act, because the injuries sustained caused a 10% disability of the person-as-a-whole (50 weeks), 5% disability of the right arm (12.65 weeks), 5% disability of the right hand (10.25 weeks), 7.5% disability of the right leg (16.125 weeks), and 7.5% disability of the left leg (16.125 weeks).

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $69,400.00.The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 24, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-8/19/21
068

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

/s/ *Stephen Mathis*
Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LISAK, CELESTE
Employee/Petitioner

Case# **12WC011061**
15WC009792

CITY OF CHICAGO - FLEET MEMT
Employer/Respondent

On 4/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4642 O'CONNOR & NAKOS
STEPHEN CUMMINGS
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CELESTE LISAK
Employee/Petitioner

v.

CITY OF CHICAG0 - FLEET MGMT.
Employer/Respondent

Case # **12**WC **11061**

Consolidated cases: **15 WC 09792**

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 **Arbitrator Charlie Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **June 11, 2019**. By stipulation, the parties agree:

On the date of accident, **January 3, 2012**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**40,014.00**, and the average weekly wage was $**769.50**.

At the time of injury, Petitioner was **73** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**15,099.51** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**15,099.51**.

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

1) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **50** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 10% loss of use of the person as a whole, relative to her right shoulder**.

2) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **12.65** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 5% loss of use of the arm.**

3) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **10.25** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 5% loss of use of the right hand.**

4) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 7.5% loss of use of the leg, relative to her right leg/knee.**

5) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 7.5% loss of use of the left leg, relative to her left leg/knee.**

Respondent shall pay Petitioner compensation that has accrued from **1/3/12** through **6/11/19**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 27, 2020
Date

APR 3 - 2020

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

CELESTE LISAK,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO. 12 WC 11061
	)	(Consolidated with 15 WC 09792)
	)	
CITY OF CHICAGO – FLEET MGMT.	)	
	)	Arbitrator Charlie Watts
Respondents.	)	

I. STATEMENT OF FACTS

The parties have stipulated that Celeste Lisak, hereinafter referred to as Petitioner, was involved in an accident arising out of her employment with the City of Chicago, hereinafter referred to as Respondent, on January 3, 2012. The parties further stipulate that proper notice of the accident was given. Further, the parties stipulate that the Petitioner's current condition of ill-being is causally connected to this work injury. Further, the parties have stipulated that Petitioner's earnings in the year prior to her accident were $40,014.00 and her average weekly wage was $769.50. In addition, the parties have stipulated that at the time of her accident, Petitioner was 73 years old, single with zero dependent children. The parties further stipulate that Respondent has paid the reasonable, necessary and causally related medical expenses incurred. (Arbitrator's Exhibit No. 1)

In addition, the parties have stipulated that Petitioner was temporary and totally disabled from January 4, 2012 through July 27, 2012 representing 29 weeks. The parties further stipulated that during that time period, Respondent has paid $15,099.51 in temporary total disability. The only issue in dispute is the nature and extent of Petitioner's injuries. (Arbitrator's Exhibit No. 1)

Petitioner testified that when she began work on January 3, 2012 she felt absolutely fine with no pain or symptoms in any body party whatsoever. Petitioner's testimony is unrebutted. On January

3, 2012, Petitioner was employed as a Watchman for Respondent. As a Watchman, Petitioner was responsible for securing the perimeter of the facility located at 2451 S. Ashland, Chicago, Illinois. Petitioner's testimony in this regard is unrebutted. Petitioner further testified that on that date, she stepped into an area on the floor in which a tile had come loose tripping her and causing her to fall onto her bilateral knees and outstretched right arm and right side. Petitioner's testimony is unrebutted and corroborated by the medical histories and evidence. Petitioner testified that she experienced the immediate onset of severe pain in her right shoulder, right elbow, right wrist, and bilateral knees. Petitioner further testified that she was unable to get up and was ultimately transported to the emergency room by Chicago Fire Ambulance.

Petitioner was transported to University of Illinois Hospital on January 3, 2012. On that date, she provided a consistent history of a fall at work. She underwent follow-up care and treatment at the University of Illinois Medical Center, Advanced Occupational Medical Specialists, Northshore Orthopedics Group, U.S. Healthworks and Accelerated Rehabilitation. (Petitioner's Exhibits 1 through 7) During the course of her care and treatment, Petitioner was ultimately diagnosed with the following:

1. Right shoulder tear of the superior glenoid labrum and rotator cuff tendinopathy.
2. Right elbow lateral epicondylitis.
3. Right wrist radial styloid tenosynovitis
4. Bilateral knee injuries post previous knee replacements.

Petitioner underwent care and treatment and rehabilitation relative to her injuries. In addition, Petitioner underwent a Functional Capacity Evaluation. This Functional Capacity Evaluation was performed on July 11, 2012. Petitioner was returned back to work with permanent restrictions as delineated by the Functional Capacity Evaluation. (Petitioner's Exhibit #2 pgs. 127-132)

Respondent was able to accommodate Petitioner's permanent restrictions as delineated by the Functional Capacity Evaluation. Petitioner returned to work for Respondents as a Watchman on July 27, 2012. Petitioner was taken off work by her treating doctors from January 4, 2012 to July 27, 2012. During this time Respondent paid Petitioner her workers' compensation benefits. Petitioner has performed the duties of watchman from July 27, 2012 until she was involved in a subsequent accident on March 3, 2015.

Petitioner testified that prior to January 3, 2012, she had undergone a right knee replacement in 2005 and a left knee replacement in 2008. Petitioner's unrebutted testimony is that after the knee replacements and rehabilitation, she was experiencing absolutely no symptoms or problems with respect to her bilateral knees. Petitioner testified that she was able to ambulate without the use of a cane prior to January 3, 2012. Petitioner further testified that prior to January 3, 2012 she had never injured her right shoulder, right elbow or right wrist. Petitioner's testimony is unrebutted. In addition, Petitioner testified that she had never sought any medical treatment whatsoever to her right shoulder, right elbow and right wrist prior to January 3, 2012. In addition, Petitioner testified that she has sustained no new injuries to her right shoulder, right elbow and right wrist or bilateral knees subsequent to January 3, 2012. Petitioner's testimony is unrebutted.

II. EXPERT OPINIONS

DR. JEFFREY COE

Dr. Jeffrey Coe performed an Independent Medical Examination of Petitioner on January 19, 2016 relative to the injuries she sustained on January 3, 2012. With respect to that accident, Dr. Coe specifically opined that "There is a casual relationship between the injuries suffered by Ms. Lisak at work for the City of Chicago on January 3, 2012 (Right upper extremity and both knees)....and her current upper extremity and lower extremity symptoms and state of impairment. In my opinion, Ms.

Lisak's injuries at work for the City of Chicago on January 3, 2012 (Right upper extremity and knees)...have caused permanent disability to both arms and to the person as a whole." (Petitioner's Exhibit No. 8) In addition, Dr. Coe opined that "Ms. Lisak is in need of on-going medical treatment. Appropriate treatment at this time would be conservative with anti-inflammatory medications as prescribed by her treatment physicians." (Petitioner's Exhibit No. 8)

III. FINDINGS

F). WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator adopts his findings of fact and law contained in the Statement of Facts, and incorporates them herein by this reference.

The medical evidence clearly demonstrates that Petitioner has been consistently diagnosed with a right shoulder labrum tear, right shoulder rotator cuff tendinopathy, right elbow lateral epicondylitis, right wrist radial styloid tenosynovitis and bilateral knee injury post bilateral knee replacements. Petitioner has undergone non-surgical care and treatment for these injuries. Petitioner was ultimately released back to work within permanent restrictions outlined by her Functional Capacity Evaluation. Petitioner's restrictions were accommodated by Respondent, specifically the restrictions did not prevent her from returning to her previous employment as a Watchman.

Petitioner's unrebutted testimony is that prior to her accident on January 3, 2012, she was experiencing absolutely no symptoms in her right shoulder, right elbow, right wrist or bilateral knees. Petitioner specifically testified that she was able to ambulate without the use of a cane prior to her accident. The Arbitrator notes that the Petitioner's testimony in this regard is unrebutted. Petitioner further testified that following her January 3, 2012 accident, she has experienced and continues to experience pain and symptoms in her right shoulder, right elbow, right wrist and bilateral knees. Petitioner's testimony is unrebutted and corroborated by her treating medical records. Further,

Petitioner's unrebutted testimony is that subsequent to her January 3, 2012 accident, she requires a cane in order to ambulate safely.

In addition, Petitioner has testified that physical activities performed upon her return to work as well in her daily life will increase the symptoms in right shoulder, right elbow, right wrist and bilateral knees. The Arbitrator again notes that the Petitioner's testimony in this regard is unrebutted. Finally, Dr. Coe has opined that Petitioner's injuries have resulted in permanent partial disability. (Petitioner's Exhibit No. 8)

Based upon the above, the Arbitrator finds that Petitioner's injuries to her right shoulder, right elbow, right wrist and bilateral knees cause her to be permanently and partially disabled.

Specifically, the Arbitrator finds with respect to Petitioner's right shoulder, (labrum tear and rotator cuff tendinopathy) she is permanently and partially disabled to the extent of 10% loss of use of the person as a whole.

With respect to Petitioner's right elbow, (lateral epicondylitis) the Arbitrator finds Petitioner to be permanently and partially disabled to the extent of 5% loss of use of the arm.

With respect to Petitioner's right hand/wrist (radial styloid tenosynovitis) the Arbitrator finds that Petitioner has been permanently and partially disabled to the extent of 5% loss of use of the right hand.

With respect to the Petitioner's right knee, the Arbitrator finds that Petitioner has been permanently and partially disabled to the extent of 7.5% loss of use of the right leg.

With respect to the Petitioner's left knee, the Arbitrator finds that Petitioner has been permanently and partially disabled to the extent of 7.5% loss of use of the left leg.

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CELESTE LISAK,
Petitioner,

vs.

No. 12 WC 11061
IWCC # 21IWCC0436

CITY OF CHICAGO—FLEET MANAGEMENT,
Respondent.

ORDER

The Commission finds that a clerical error exists in its Decision and Opinion on Review dated August 24, 2021, in the above-captioned matter, and on its own motion, pursuant to Section 19(f) of the Act, vacates and recalls that Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review in the above-captioned matter, dated August 24, 2021, is hereby vacated and recalled pursuant to Section 19(f) for correction of a clerical error contained therein.

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

August 25, 2021

/s/ *Marc Parker*
Marc Parker

mp/dk
68

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Celeste Lisak,
Petitioner,

vs.

No. 12 WC 011061
(consolidated with 15 WC 009792)

City of Chicago—Fleet Management,
Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of clerical error and nature and extent of permanent disability, 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 nature and extent of Petitioner's leg injuries, the Arbitrator found that the injuries sustained caused a 7.5% loss of use of each leg. However, his Order awarded only 10.75 weeks for each leg. The Commission finds that this was a clerical error and modifies the Decision to reflect the proper number of weeks for each leg, 16.125 weeks. 820 ILCS 305 §8(e)12.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2020 is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner $461.70 per week for a period of 105.15 weeks, as provided in §8(d)2 and §8(e) of the Act, because the injuries sustained caused a 10% disability of the person-as-a-whole (50 weeks), 5% disability of the right arm (12.65 weeks), 5% disability of the right hand (10.25 weeks), 7.5% disability of the right leg (16.125 weeks), and 7.5% disability of the left leg (16.125 weeks).

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

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 25, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-8/19/21
068

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

/s/ *Stephen Mathis*
Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LISAK, CELESTE
Employee/Petitioner

Case# **12WC011061**
15WC009792

CITY OF CHICAGO - FLEET MEMT
Employer/Respondent

On 4/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4642 O'CONNOR & NAKOS
STEPHEN CUMMINGS
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CELESTE LISAK
Employee/Petitioner

v.

CITY OF CHICAG0 - FLEET MGMT.
Employer/Respondent

Case # **12**WC **11061**

Consolidated cases: **15 WC 09792**

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 **Arbitrator Charlie Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **June 11, 2019**. By stipulation, the parties agree:

On the date of accident, **January 3, 2012**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**40,014.00**, and the average weekly wage was $**769.50**.

At the time of injury, Petitioner was **73** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**15,099.51** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**15,099.51**.

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

1) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **50** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 10% loss of use of the person as a whole, relative to her right shoulder**.

2) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **12.65** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 5% loss of use of the arm.**

3) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **10.25** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 5% loss of use of the right hand.**

4) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 7.5% loss of use of the leg, relative to her right leg/knee.**

5) Respondent shall pay Petitioner the sum of $**461.70**/week for a further period of **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **permanent partial disabilitly to the extent of 7.5% loss of use of the left leg, relative to her left leg/knee.**

Respondent shall pay Petitioner compensation that has accrued from **1/3/12** through **6/11/19**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 27, 2020
Date

APR 3 - 2020

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

CELESTE LISAK,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO. 12 WC 11061
	)	(Consolidated with 15 WC 09792)
	)	
CITY OF CHICAGO – FLEET MGMT.	)	
	)	Arbitrator Charlie Watts
Respondents.	)	

I. STATEMENT OF FACTS

The parties have stipulated that Celeste Lisak, hereinafter referred to as Petitioner, was involved in an accident arising out of her employment with the City of Chicago, hereinafter referred to as Respondent, on January 3, 2012. The parties further stipulate that proper notice of the accident was given. Further, the parties stipulate that the Petitioner's current condition of ill-being is causally connected to this work injury. Further, the parties have stipulated that Petitioner's earnings in the year prior to her accident were $40,014.00 and her average weekly wage was $769.50. In addition, the parties have stipulated that at the time of her accident, Petitioner was 73 years old, single with zero dependent children. The parties further stipulate that Respondent has paid the reasonable, necessary and causally related medical expenses incurred. (Arbitrator's Exhibit No. 1)

In addition, the parties have stipulated that Petitioner was temporary and totally disabled from January 4, 2012 through July 27, 2012 representing 29 weeks. The parties further stipulated that during that time period, Respondent has paid $15,099.51 in temporary total disability. The only issue in dispute is the nature and extent of Petitioner's injuries. (Arbitrator's Exhibit No. 1)

Petitioner testified that when she began work on January 3, 2012 she felt absolutely fine with no pain or symptoms in any body party whatsoever. Petitioner's testimony is unrebutted. On January

3, 2012, Petitioner was employed as a Watchman for Respondent. As a Watchman, Petitioner was responsible for securing the perimeter of the facility located at 2451 S. Ashland, Chicago, Illinois. Petitioner's testimony in this regard is unrebutted. Petitioner further testified that on that date, she stepped into an area on the floor in which a tile had come loose tripping her and causing her to fall onto her bilateral knees and outstretched right arm and right side. Petitioner's testimony is unrebutted and corroborated by the medical histories and evidence. Petitioner testified that she experienced the immediate onset of severe pain in her right shoulder, right elbow, right wrist, and bilateral knees. Petitioner further testified that she was unable to get up and was ultimately transported to the emergency room by Chicago Fire Ambulance.

Petitioner was transported to University of Illinois Hospital on January 3, 2012. On that date, she provided a consistent history of a fall at work. She underwent follow-up care and treatment at the University of Illinois Medical Center, Advanced Occupational Medical Specialists, Northshore Orthopedics Group, U.S. Healthworks and Accelerated Rehabilitation. (Petitioner's Exhibits 1 through 7) During the course of her care and treatment, Petitioner was ultimately diagnosed with the following:

1. Right shoulder tear of the superior glenoid labrum and rotator cuff tendinopathy.
2. Right elbow lateral epicondylitis.
3. Right wrist radial styloid tenosynovitis
4. Bilateral knee injuries post previous knee replacements.

Petitioner underwent care and treatment and rehabilitation relative to her injuries. In addition, Petitioner underwent a Functional Capacity Evaluation. This Functional Capacity Evaluation was performed on July 11, 2012. Petitioner was returned back to work with permanent restrictions as delineated by the Functional Capacity Evaluation. (Petitioner's Exhibit #2 pgs. 127-132)

Respondent was able to accommodate Petitioner's permanent restrictions as delineated by the Functional Capacity Evaluation. Petitioner returned to work for Respondents as a Watchman on July 27, 2012. Petitioner was taken off work by her treating doctors from January 4, 2012 to July 27, 2012. During this time Respondent paid Petitioner her workers' compensation benefits. Petitioner has performed the duties of watchman from July 27, 2012 until she was involved in a subsequent accident on March 3, 2015.

Petitioner testified that prior to January 3, 2012, she had undergone a right knee replacement in 2005 and a left knee replacement in 2008. Petitioner's unrebutted testimony is that after the knee replacements and rehabilitation, she was experiencing absolutely no symptoms or problems with respect to her bilateral knees. Petitioner testified that she was able to ambulate without the use of a cane prior to January 3, 2012. Petitioner further testified that prior to January 3, 2012 she had never injured her right shoulder, right elbow or right wrist. Petitioner's testimony is unrebutted. In addition, Petitioner testified that she had never sought any medical treatment whatsoever to her right shoulder, right elbow and right wrist prior to January 3, 2012. In addition, Petitioner testified that she has sustained no new injuries to her right shoulder, right elbow and right wrist or bilateral knees subsequent to January 3, 2012. Petitioner's testimony is unrebutted.

II. EXPERT OPINIONS

DR. JEFFREY COE

Dr. Jeffrey Coe performed an Independent Medical Examination of Petitioner on January 19, 2016 relative to the injuries she sustained on January 3, 2012. With respect to that accident, Dr. Coe specifically opined that "There is a casual relationship between the injuries suffered by Ms. Lisak at work for the City of Chicago on January 3, 2012 (Right upper extremity and both knees)....and her current upper extremity and lower extremity symptoms and state of impairment. In my opinion, Ms.

Lisak's injuries at work for the City of Chicago on January 3, 2012 (Right upper extremity and knees)...have caused permanent disability to both arms and to the person as a whole." (Petitioner's Exhibit No. 8) In addition, Dr. Coe opined that "Ms. Lisak is in need of on-going medical treatment. Appropriate treatment at this time would be conservative with anti-inflammatory medications as prescribed by her treatment physicians." (Petitioner's Exhibit No. 8)

III. FINDINGS

F). WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator adopts his findings of fact and law contained in the Statement of Facts, and incorporates them herein by this reference.

The medical evidence clearly demonstrates that Petitioner has been consistently diagnosed with a right shoulder labrum tear, right shoulder rotator cuff tendinopathy, right elbow lateral epicondylitis, right wrist radial styloid tenosynovitis and bilateral knee injury post bilateral knee replacements. Petitioner has undergone non-surgical care and treatment for these injuries. Petitioner was ultimately released back to work within permanent restrictions outlined by her Functional Capacity Evaluation. Petitioner's restrictions were accommodated by Respondent, specifically the restrictions did not prevent her from returning to her previous employment as a Watchman.

Petitioner's unrebutted testimony is that prior to her accident on January 3, 2012, she was experiencing absolutely no symptoms in her right shoulder, right elbow, right wrist or bilateral knees. Petitioner specifically testified that she was able to ambulate without the use of a cane prior to her accident. The Arbitrator notes that the Petitioner's testimony in this regard is unrebutted. Petitioner further testified that following her January 3, 2012 accident, she has experienced and continues to experience pain and symptoms in her right shoulder, right elbow, right wrist and bilateral knees. Petitioner's testimony is unrebutted and corroborated by her treating medical records. Further,

Petitioner's unrebutted testimony is that subsequent to her January 3, 2012 accident, she requires a cane in order to ambulate safely.

In addition, Petitioner has testified that physical activities performed upon her return to work as well in her daily life will increase the symptoms in right shoulder, right elbow, right wrist and bilateral knees. The Arbitrator again notes that the Petitioner's testimony in this regard is unrebutted. Finally, Dr. Coe has opined that Petitioner's injuries have resulted in permanent partial disability. (Petitioner's Exhibit No. 8)

Based upon the above, the Arbitrator finds that Petitioner's injuries to her right shoulder, right elbow, right wrist and bilateral knees cause her to be permanently and partially disabled.

Specifically, the Arbitrator finds with respect to Petitioner's right shoulder, (labrum tear and rotator cuff tendinopathy) she is permanently and partially disabled to the extent of 10% loss of use of the person as a whole.

With respect to Petitioner's right elbow, (lateral epicondylitis) the Arbitrator finds Petitioner to be permanently and partially disabled to the extent of 5% loss of use of the arm.

With respect to Petitioner's right hand/wrist (radial styloid tenosynovitis) the Arbitrator finds that Petitioner has been permanently and partially disabled to the extent of 5% loss of use of the right hand.

With respect to the Petitioner's right knee, the Arbitrator finds that Petitioner has been permanently and partially disabled to the extent of 7.5% loss of use of the right leg.

With respect to the Petitioner's left knee, the Arbitrator finds that Petitioner has been permanently and partially disabled to the extent of 7.5% loss of use of the left leg.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC033906
Case Name	FLOWERS, DARRELL W SR v. CHGO STREETS & SAN DEPT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0437
Number of Pages of Decision	11
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Scott Shapiro
Respondent Attorney	Matthew Locke

DATE FILED: 8/27/2021

/s/Stephen Mathis, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DARRELL FLOWERS,

Petitioner,

vs. NO: 14 WC 33906

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent of disability, and being advised of the facts and law, corrects and otherwise affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the clerical error in the Order part of the Arbitrator's Decision to reflect, consistent with Findings, an award of temporary total disability benefits of $906.67/ week for 28 weeks, commencing April 19, 2014 through October 31, 2014. All else is affirmed and adopted

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 2, 2020 is hereby corrected, as stated herein and otherwise affirmed and adopted

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

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

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.

August 27, 2021

o-7/28/21
SM/msb
44

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

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

/s/*Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLOWERS, DARRELL
Employee/Petitioner

Case# **14WC033906**

CITY OF CHICAGO DEPT OF STREETS AND SANITATION
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:

4703 LAW OFFICES OF SCOTT B SHAPIRO
218 N JEFFERSON ST
SUITE 401
CHICAGO, IL 60661

0010 CITY OF CHICAGO DEPT OF LAW
MATTHEW LOCKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

21IWCC0437

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Darrell Flowers
Employee/Petitioner

v.

City of Chicago Department of Streets and Sanitation
Employer/Respondent

Case # **14** WC **33906**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 9, 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **April 18, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,720.00**; the average weekly wage was $**1,360.00**.

On the date of accident, Petitioner was**58** 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 $**21,532.32** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**7,835.05** for statutory loss benefits, for a total credit of $**29,367.37**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$8,957.72,** as provided in Sections 8(a) and 8.2 of the Act. Respondent agreed to pay any unpaid medical bills directly to the providers and Petitioner agreed to this stipulation.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**906.67**/week for **28** weeks, commencing **April 9, 2014** through **October 31, 2014**, for a total of **$25,386.76** as provided in Section 8(b) of the Act. Respondent shall be given a credit in the amount of **$21,532.32**. The Arbitrator finds Petitioner entitled to an additional **$3,854.44** in unpaid/underpaid TTD benefits.

Permanent Partial Disability

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 60% loss of use of the left small finger, or $ ($735.37 x 13.2 = $9,706.88). Respondent shall be given a credit for statutory loss payments in the amount of $7,838.05. Respondent underpaid Petitioner's statutory loss payments. The Arbitrator finds Petitioner entitled to an additional $1,868.83 for the left small finger. The Arbitrator finds Petitioner sustained permanent partial disability to the extent of 25% loss of use of the left ring finger totaling $4,963.75 ($735.37 x 6.75 = $4,963.75).

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

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

Signature of Arbitrator

12-01-20
Date

DEC 2 - 2020

DECISION OF ARBITRATOR
DARRELL FLOWERS v. CITY OF CHICAGO
IWCC No.: 14 WC 33906

Analysis and Conclusions of Law

J. Regarding whether the medical services that were provided to Petitioner reasonable and necessary, and whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator finds all medical services provided to Petitioner were reasonable and necessary. Petitioner submitted as Petitioner's Exhibit #3 unpaid medical bills in the amount of $8,957.72 owed to Northwestern Hospital Medical Group. The Arbitrator finds Respondent liable for any and all medical bills incurred by Petitioner and awards the bills in the amount of $8,957.72 to be paid by Respondent to Northwestern Hospital Medical Group. Respondent stipulated, and Petitioner agreed, that any bills which remain outstanding would be paid directly to the medical providers.

K. Regarding what temporary total disability benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator finds Respondent liable for TTD benefits for the period of October 4, 2014 through October 31, 2014. Dr. Stogin in his September 2, 2014 office note indicated Petitioner could return to work in approximately 4 weeks after completing occupational therapy. Petitioner introduced into evidence as Petitioner's Exhibit #4 the note from Dr. Stogin releasing Petitioner to full duty on October 28, 2014. (PX #4). Petitioner testified he returned to work on November 1, 2014. Petitioner introduced into evidence as Petitioner's Exhibit #5 emails from Respondent refusing to allow Petitioner to return to work prior to November 1, 2014 and stating that he remained on duty disability. Respondent stipulated it only paid Petitioner TTD from April 19, 2014 through October 3, 2014, and also introduced into evidence payment logs indicating it only paid Petitioner through October 3, 2014.

The Arbitrator finds Petitioner entitled to TTD for the period of April 19, 2014 through October 31, 2014, a period of 28 weeks. Based upon Petitioner's TTD rate of $906.67, Petitioner is entitled to TTD in the amount of $25,386.76 ($906.67 x 28 = $25,386.76). The Arbitrator finds Respondent entitled to a credit in the amount of $21,532.32 in TTD benefits, and Petitioner entitled to additional TTD benefits in the amount of $3,854.44, representing unpaid/underpaid TTD benefits.

L. Regarding what is the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator finds Petitioner sustained permanent partial disability to both the left small finger and the left ring finger. The Arbitrator notes Petitioner demonstrated severe loss of motion in the left small finger and testified to numbness along the finger and down into his hand below the left small finger. Based on the foregoing Arbitrator finds Petitioner entitled to 60% loss of use of the left small finger for a total of ($735.37 x 13.2 = $9,706.88). Respondent shall be given a credit for statutory loss payments in the amount of $7,838.05. The Arbitrator finds Respondent underpaid the statutory loss benefits. In summary, the Arbitrator finds Petitioner entitled to an additional $1,868.83 in "fresh money" for the left small finger.

The Arbitrator further finds Petitioner sustained permanent partial disability of the left ring finger to the extent of 25% loss of use of the left ring finger totaling $4,963.75 ($735.37 x 6.75 = $4,963.75).

Kurt Carlson, Arbitrator

12.01.20

Date

DECISION OF ARBITRATOR
DARRELL FLOWERS v. CITY OF CHICAGO
IWCC No.: 14 WC 33906

STATEMENT OF FACTS

Petitioner, Darrell Flowers (hereinafter "Petitioner") was employed by the City of Chicago Department of Streets and Sanitation (hereinafter "Respondent") as a garbage collector. On April 18, 2014, Petitioner loaded discarded wood into a machine, and the blade of the machine came down on Petitioner's left hand. The blade caught Petitioner's left small finger and ring finger. Petitioner testified he felt a pinch, and immediate pain. He was able to wiggle his hand to extricate it from the machine, and upon removing his glove he notice his finger was bleeding, and the tip of his left small finger was hanging off, and his left ring finger was painful.

Petitioner immediately reported the accident to his supervisor. He was transported to Northwestern Memorial Hospital emergency room. Emergency surgery was performed by Dr. John Stogin, on April 14, 2014 to remove the severed portion of his left small finger. He was also diagnosed with a fracture of the left ring finger. Post surgically Petitioner was restricted from work beginning April 15, 2014. (PX #1).

Petitioner continued to follow up with Dr. Stogin, who referred Petitioner for occupational therapy at Northwestern. Petitioner continued to follow up with Dr. Stogin from April 23, 2014 through August 21, 2014. On August 21, 2014, Dr. Stogin performed a second surgery and excised a neuroma from Petitioner's left small finger which developed post surgically. On September 2, 2014, Dr. Stogin continued to restrict Petitioner from work, and prescribed physical therapy, and opined after therapy Petitioner could possibly return to unrestricted work in four weeks. Petitioner continue to attend occupational therapy at Northwestern through September 23, 2014. Dr. Stogin thereafter released Petitioner to return to

full duty work on October 28, 2014. (PX 4).

Petitioner testified Respondent paid him TTD benefits for the period of April 19, 2014 through October 3, 2014. Petitioner testified, he attempted to return to work and contacted Respondent via telephone and email. Respondent would not allow him to return and questioned whether he still had restrictions. (PX #5). Respondent stipulated it only paid Petitioner TTD through October 3, 2014. Petitioner then sought a second opinion with Dr. Victor Romano of Hinsdale Orthopedics on November 5, 2014. Dr. Romano also released Petitioner to return to work full duty on November 5, 2014. Prior to this release Petitioner stated Respondent finally allowed him to return to work on November 1, 2014.

At trial Petitioner testified he still suffers from pain in his small finger, and ring finger. In addition, he testified he has numbness in his small finger, which extends into the outside of his hand, and he experiences weakness in the finger. Petitioner demonstrated at trial the significant loss of flexion and extension in his left small finger. He testified that although he returned to work full duty, he had to be careful and work around the loss of use of his left small finger.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC028384
Case Name	THOMAS, DAWN S v. TEENCHY WEENCHY DAYCARE & LEARNING CNTR
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0438
Number of Pages of Decision	20
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Kenneth Lubinski
Respondent Attorney	Ndubuisi Vincent Obah

DATE FILED: 8/30/2021

/s/Christopher Harris, 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

DAWN THOMAS,

Petitioner,

vs. NO: 14 WC 28384

TEENCHY WEENCHY DAYCARE &
ILLINOIS STATE TREASURER AS EX-OFFICIO
CUSTODIAN OF THE INJURED WORKERS' BENEFIT
FUND,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical treatment, temporary total disability (TTD), and permanent partial disability (PPD), 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.

In his Order, the Arbitrator found that Petitioner has "received all reasonable and necessary medical care related to her accident and that the billing for said reasonable and necessary medical care bear zero balances." The Petitioner testified that Respondent, Teenchy Weenchy, did not provide health insurance nor did they carry workers' compensation insurance. Petitioner's Exhibit 1 demonstrates that payments were made on Petitioner's behalf totaling $420.25 to Franciscan Alliance, Roseland Community Hospital, and St. Bernard Hospital. The treatment Petitioner received at those hospitals was the result of her work-related accident and was reasonable and

necessary. Therefore, Respondent shall pay $420.25 to the Petitioner directly for payments made on her behalf.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 15, 2020 is hereby modified as stated above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $420.25 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $319.00 per week for 9.3 weeks, because the injuries sustained caused 2.5% loss of use of the left foot (4.175 weeks) and 2.5% loss of use of the left wrist (5.125 weeks) under Section 8(e) 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 the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award hereby is entered against the Fund to the extent permitted and allowed under § 4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund. The Respondent-Employer's obligation to reimburse the Injured Workers' Benefit Fund, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

August 30, 2021

Christopher A. Harris
Christopher A. Harris

CAH/tdm
O: 8/19/21
052

Stephen Mathis
Stephen Mathis

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0438

THOMAS, DAWN
Employee/Petitioner

Case# **14WC028384**

TEENCHY WEENCHY DAYCARE & ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 6/15/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1497 MORICI FIGLIOLI & ASSOCIATES
KENNETH LUBINSKI
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

0000 TEENCHY WEENCHY DAYCARE &
LEARNING CENTER INC
901 E 104TH ST
CHICAGO, IL 60628

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dawn Thomas
Employee/Petitioner

Case # **14 WC 28384**

v.

Teenchy Weenchy Daycare & Illinois State Treasurer, as *ex-officio* Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Arbitrator **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **December 30, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

O. ☐ Other: _____

FINDINGS

On **July 30, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** 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's wages were **$24,960.00**, for an average weekly wage of **$480.00**.

On the date of accident, Petitioner was **27** years of age, single, 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** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

The Arbitrator found that Petitioner failed to prove that she was entitled to temporary total disability benefits and therefore Petitioner's claim for TTD is denied.

The Arbitrator found that Petitioner has received all reasonable and necessary medical care related to her accident and that the billing for said reasonable and necessary medical care bear zero balances. The Arbitrator finds that Respondent does not owe any medical benefits as provided in §8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits corresponding to a 2.5% loss of use of the left foot and a 2.5% loss of use of the left wrist, 9.3 weeks of PPD.

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.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund ("IWBF") was named as a co-Respondent in this matter. The Treasurer was represented by the Office of the Illinois Attorney General. This finding is hereby entered as to the IWBF to the extent permitted and allowed under §4(d) of the Act, no party shall seek or have a right to any recovery from the IWBF. Should any recovery by the Petitioner occur, Respondent-Employer shall reimburse the IWBF for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the IWBF, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid, or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

Signature of Arbitrator

June 9, 2020
Date

JUN 15 2020

Dawn Thomas v. Teenchy Weenchy Daycare & Illinois State Treasurer, as *ex-officio* Custodian of the Injured Workers' Benefit Fund
14 WC28384

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***A:*** Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?; ***B:*** Was there an employee-employer relationship?; ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***D:*** What was the date of the accident?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***G:*** What were Petitioner's earnings?; ***H:*** What was Petitioner's age at the time of the accident?; ***I:*** What was Petitioner's marital status at the time of the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; **K:** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

Prior to the hearing Petitioner presented evidence of notice of the hearing on Respondent Teenchy Weenchy Daycare.

Petitioner's Exhibit #2, the June 5, 2015 subpoena response from the National Council on Compensation Insurance, confirmed that Respondent Teenchy Weenchy Daycare did not carry workers compensation insurance on the date of Petitioner's accident.

FINDINGS OF FACT

Petitioner Dawn Thomas testified that her date of birth is July 6, 1987, and that she was 27 years old on the date of the accident. On the date of the hearing, Petitioner had four dependents, aged 3, 5, 6, and 13, but on the date of the accident, she had three dependents. Petitioner was not married on the date of the accident nor was she married on the date of the arbitration hearing.

On the date of the accident, Petitioner was employed by Respondent Teenchy Weenchy Daycare as a teacher. Teenchy Weenchy Daycare is located at 901 E. 104th St., Chicago IL.

Petitioner was hired in 2012 by the owner, Jennette Hutchinson, at a rate of $12 per hour. She worked 12 hours a day, five days per week. Her job duties included teaching the children, changing diapers, and potty training the children.

The accident occurred on July 30, 2014. On that date, while performing her job duties, between approximately 12:30 - 1:30 pm, Petitioner noticed water coming from the bathroom. Upon further investigation, she saw that the toilet was overflowing, and the bathroom floor was wet. She contacted Ms. Hutchinson who told her to plunge the toilet, which she did. After plunging the toilet, as she was exiting the bathroom, she slipped and fell on the wet floor. As she was falling, she tried to catch herself but was unable to do so. Her head and face struck the sink and she then landed on the floor with her left ankle twisted underneath her.

As a result of the accident, Petitioner sustained injuries to her left hand, left arm, and left ankle. Additionally, Petitioner testified that two teeth were knocked out and a third was chipped. Petitioner also claims she sustained a concussion.

After the accident, Petitioner was taken by ambulance to Roseland Community Hospital. The EMS report notes that she had leg pain and was unable to walk (PX #3). In the emergency room at Roseland, Petitioner complained of leg, ankle and wrist pain and said that she was unable to walk. The admitting diagnoses were ankle and forearm pain, but Petitioner left against medical advice before any nursing or medical assessment was performed.

On the following day, Petitioner presented at the emergency room of St. Bernard Hospital (PX #4). She reported that she fell at work onto her left side, hitting her left wrist. Petitioner did not report striking her face or having knocked out a tooth or having a chipped tooth. She had left wrist pain, an 8/10 headache, and 8/10 pain and swelling in the left ankle. She also stated that she was unable to move her right arm. Petitioner was diagnosed with ankle sprain, wrist sprain, and headache. Ace wraps were applied to her left wrist and left ankle.

Petitioner followed up at the emergency room at Franciscan Alliance St. Margaret Mercy North Hospital (St. Margaret Mercy) in Hammond, Indiana on August 12, 2014 (PX #5). She gave a history of a fall at work on July 30, hitting her head and injuring her left foot and left wrist. Petitioner also reported she knocked out a tooth and chipped another. She had complaints of head pain, left foot pain, left wrist pain, and a headache. The physical examination noted tenderness in the left ankle but was otherwise unremarkable. There was no notation regarding missing or chipped teeth. A CT of the head was negative. X-rays of the left ankle and left hand were also negative. Petitioner

was diagnosed with left ankle sprain, hand contusion, and concussion syndrome. She was discharged with instructions to follow up with Dr. Maria Riza Batista in Chicago.

On July 31, 2014, Petitioner contacted the owner of Teenchy Weenchy, Ms. Hutchinson, to advise her of the accident and that she was unable to work. Ms. Hutchinson informed Petitioner that Teenchy Weenchy did not have workers' compensation insurance. Ms. Hutchinson also told Petitioner that she would fire her so that she could collect unemployment, which is what Petitioner ultimately received.

Petitioner did not seek additional medical treatment because she had no health insurance and Teenchy Weenchy did not have workers' compensation insurance. She continued to treat on her own by taking over-the-counter medications such as Advil for her wrist and ankle pain, and Orajel for her teeth.

Petitioner did not receive TTD benefits. Petitioner estimated that she received $250-$300 per week in unemployment benefits between August 2014 and November of 2014.

Petitioner was unemployed from the date of the accident until January 30, 2015, at which time she started a new job as a teacher at a daycare center called Kids Creative Concepts. During the period of time she was off work, she experienced pain in her ankle, wrist, and arm. She was unable to perform the job duties of a daycare teacher because she was unable to pick up and carry the children.

Since the date of the accident, Petitioner has continued to be employed as a preschool teacher. As noted above, she worked at Kids Creative Concepts where she earned $12 per hour. She also worked at another daycare called Tiny Scholars where she earned $13 per hour. Petitioner's Exhibit #9 is a pay stub from Tiny Scholars, showing that she earned $13 per hour for a two week/80-hour period. Petitioner testified that based on her own job research, the industry standard for a daycare teacher is $12-$13 per hour.

Petitioner testified to her continuing complaints of pain and that she needs to have future dental treatment in order to fix the teeth that were injured in the accident. Petitioner's Exhibit #7 is a bill from Destiny Dental from 2018, for the surgical extraction of three teeth due to the accident. Petitioner testified that a total of four teeth were removed, but only three were from the accident. The cost of the surgical extraction is $57.40 per tooth plus the cost of evaluations and films for a total bill of $406.35. Petitioner testified that Petitioner's Exhibit #8 is an estimate from Clear Choice Dental

Implant Center for the cost of implants to replace the teeth that were extracted due to the accident. The total cost for the implants is $17,500.

Petitioner's Exhibit #1 lists the bills that Petitioner incurred as a result of the accident.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's testimony regarding her employment was credible. Petitioner testified that her employer's business is located at 901 E. 104th St., Chicago, IL. Respondent is a daycare facility. Petitioner testified that she was hired by the owner of Respondent, Jennette Hutchinson, in 2012, as a daycare teacher/center director. Petitioner testified that she was working as a daycare teacher for Respondent on the date of the accident. There has been no testimony to the contrary.

The Arbitrator therefore finds that Respondent Teenchy Weenchy Daycare was operating under and subject to the Illinois' Workers' Compensation.

B: Was there an employee-employer relationship?

Petitioner testified that Jennette Hutchinson, owner of Respondent Teenchy Weenchy Daycare, hired her in 2012 as a daycare teacher, two years before the accident. Petitioner testified that she worked at the direction of Ms. Hutchinson in that same capacity on the date of the accident. She testified that she was told by Ms. Hutchinson to plunge the overflowing toilet, which she did. The records from the Chicago Fire Department further substantiate that Petitioner's accident occurred at work.

The Arbitrator finds that an employer-employee relationship existed.

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

The Arbitrator finds that Petitioner proved that she sustained an accidental injury that arose out of and in the course of her employment with Respondent Teenchy Weenchy Daycare that resulted in injuries to her left hand, left arm, and left ankle, as well as a possible concussion.

Petitioner credibly testified that on the date of the accident, she attempted to plunge an overflowing toilet at the direction of her employer. As she was exiting the bathroom, she slipped and fell on the wet floor. Petitioner further testified that as she was falling, she tried to catch herself but was unable to do so. Petitioner consistently provided this history of her accident to her healthcare providers. Maintaining a safe bathroom in a daycare center is an essential part of providing safe daycare for children.

Based on the above facts, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent Teenchy Weenchy Daycare.

D: What was the date of the accident?

The Arbitrator finds that Petitioner proved that her work accident occurred on July 30, 2014.

E: Was timely notice of the accident given to Respondent?

The Arbitrator finds that Petitioner proved that she gave timely notice of her accident to respondent. Petitioner's credible evidence that she notified Ms. Hutchinson of her accident immediately following the accident was unrebutted.

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

The Arbitrator finds that the Petitioner's condition of ill-being in her left ankle, left wrist and with headaches is causally related to the work accident she sustained on July 30, 2014. This finding is based upon Petitioner's testimony and on the medical records submitted into evidence. However, the arbitrator finds the petitioner failed to prove that her claimed condition of ill-being with regard to her teeth was causally related to her work accident.

It is well established that causal connection can be established by a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability. This is sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. Moreover, causal connection between work duties and an injured condition may be established by a chain of events including claimant's ability to perform duties before the date of an accident and inability to perform those same duties following the date of accident.

The chain of events in this case demonstrates that Petitioner testified that she had no prior problems or injuries to her left ankle, left wrist, headaches or injuries to her teeth,

that she then sustained an accident and resulting injuries on July 30, 2014, which resulted in a period of disability. This set of facts sufficiently proves a causal nexus between the accident and Petitioner's injuries to her left wrist and left ankle, as well as headaches.

Petitioner testified that she did not have pain in her head, face, left ankle, left wrist, or damage to her teeth before the accident, and that she did not experience headaches prior to the accident. As noted above, Petitioner testified to the injuries she sustained at work. She then testified that following the accident, she felt pain in her head, face, left ankle, left wrist, felt teeth pain, and experienced headaches. This testimony stands unrebutted.

The medical records admitted in evidence further support a finding that Petitioner's various symptoms with her left wrist, left ankle, and with headaches started after the accident on July 30, 2014. However, none of the medical records admitted in evidence contains documentation that Petitioner reported that she struck her face and knocked out a tooth and chipped another when she fell at work. The records Petitioner submitted into evidence relating to her claim of dental injury were merely billing statements four years after the event and without clinical records or a care provider's causation opinion.

The Arbitrator has considered all medical evidence along with the testimony. The Arbitrator finds that a causal connection exists between Petitioner's condition of ill-being with only her left wrist, left ankle, and with headaches and the work accident she sustained on July 30, 2014.

G: What were Petitioner's earnings?

Petitioner testified that she earned $12 per hour, working 12 hours per day, five days per week. This 60-hour work week was her regular work week. The Arbitrator finds Petitioner's testimony was credible and therefore finds that Petitioner's earnings at the time of the accident were $720 per week.

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

Petitioner's testimony that she was born on July 6, 1987 and that she was 27 years old on the day she was injured was unrebutted.

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

Petitioner testified that she was not married and with three minor dependents at the time of the accident. The Arbitrator finds that Petitioner's testimony was credible and

therefore finds that the Petitioner was single with three minor dependents 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?

The Arbitrator finds that the medical treatment Petitioner received at Roseland Community Hospital, St. Bernard's Hospital, and Franciscan Alliance St. Margaret Mercy North Hospital was reasonable and necessary to treat Petitioner's injuries which were causally related to the work accident she sustained on July 30, 2014. The Arbitrator also finds that the medical bills submitted by those three institutions, as included in Petitioner's Exhibit #1, constitute reasonable and necessary fees and charges for medical treatment pursuant to §8(a) of the Act.

Petitioner claimed that to two of her teeth were knocked out and a third was chipped. The records submitted by Petitioner do not substantiate that she suffered those claimed injuries. The records from the three emergency departments where Petitioner sought immediate care did not document a report that petitioner sustained a facial or dental injury. The Arbitrator finds that Petitioner failed to prove that the dental care she testified to in the bills relating to that care were reasonable and necessary to cure or relieve the effects of the injuries she sustained in her work accident on July 30, 2014.

In light of the above, the Arbitrator awards the bills for Roseland Community Hospital, St. Bernard's Hospital, and St. Margaret Mercy North Hospital, all of which carry a zero balance.

K: What temporary benefits are in dispute? TTD

Petitioner testified that she was unable to work following the accident and that, due to a lack of workers compensation insurance, her employer terminated her. Petitioner did not obtain employment until January 30, 2015. She testified that during the period of time between the accident and the date that she returned to work, the pain to her ankle, wrist, and arm prevented her from performing her job duties.

However, none of the healthcare providers who examined or treated Petitioner restricted her from work or imposed limitations on her ability to work. Accordingly, the Arbitrator finds that Petitioner failed to prove that she was entitled to total temporary disability benefits.

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

Petitioner's permanent partial disability was evaluated in accord with §8.1b(b) of the Act:

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

ii) Petitioner's current occupation is that of a daycare teacher. The physical demands of the job involve picking up and carrying children on a frequent basis throughout a normal workday. She also is required to bend and twist to perform activities with small children and to change diapers when needed. Given these required job duties, the Arbitrator finds that the injuries sustained by Petitioner will affect her ability to perform these job duties. The Arbitrator gives great weight to this factor.

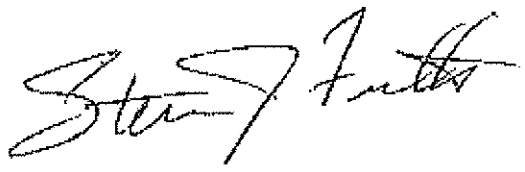
iii) Petitioner was 27 years old at the time of her accident. She had a statistical life expectancy of approximately 52 years. As a younger person Petitioner will remain in the workforce for a significant period of time. As a result, Petitioner's injuries may affect her as she continues to work. The Arbitrator gives moderate weight to this factor.

iv) Petitioner's future earnings do not appear to be diminished in any way by this injury. The petitioner testified that she currently performs the job duties of a preschool teacher and that her hourly rate is within the range of pay offered by employers for this type of position. The Arbitrator gives little weight to this factor.

v) The medical records establish that Petitioner sought emergency medical care at three separate hospitals, only two of which actually provided care. She left Roseland Community Hospital against medical advice without receiving nursing or medical assessment, much less treatment. Petitioner received cursory assessment and care at St. Bernard's Hospital. She had more comprehensive assessment at St. Margaret Mercy North, which included a CT scan and x-rays, but was only diagnosed with a left ankle sprain, a left wrist sprain, and a headache. Treatment consisted of applying Ace wraps to her ankle and wrist and providing pain relief medication. Petitioner neither sought nor received follow-up care for her ankle or wrist.
Four years later Petitioner sought care for her claimed dental injuries. Records submitted in evidence did not support a finding of causal connection to Petitioner's claimed dental injuries.
The Arbitrator gives great weight to this factor.

The Arbitrator reviewed all the evidence and in assessing Petitioner's claim for permanent partial disability in accord with the above five factors found that Petitioner

sustained a left ankle sprain which caused a 2.5% loss of use of the left foot and a left wrist sprain which caused a 2.5% loss of use of the left hand, 9.3 weeks of PPD benefits.



June 9, 2020

Steven J. Fruth, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC006417
Case Name	BUTLER, MARIE v. IL DEPT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0439
Number of Pages of Decision	27
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Nancy Shepard
Respondent Attorney	Drew Dierkes

DATE FILED: 8/30/2021

/s/ Kathryn Doerries, 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIE BUTLER,

Petitioner,

vs. NO: 15 WC 06417

ILLINOIS DEPARTMENT OF TRANSPORTATION (IDOT),

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 25, 2019 is hereby affirmed and adopted.

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

August 30, 2021

o- 8/24/21
KAD/jsf

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0439
NOTICE OF ARBITRATOR DECISION

BUTLER, MARIE Case# **15WC006417**

Employee/Petitioner

ILLINOIS DEPT OF TRANSPORTATION

Employer/Respondent

On 11/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

6096 ASSISTANT ATTORNEY GENERAL
JOHN CATALANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

NOV 25 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marie Butler Case # **15 WC 6417**

Employee/Petitioner

v. Arb. Kurt Carlson - Chicago

Illinois Department of Transportation
Respondent/Employer.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the City of **Chicago**, County of **Cook**, on **May 7, 2019 and September 9, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 5, 2014**, Respondent-Employer ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent-Employer.

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

In the year preceding the injury, Petitioner earned **$76,856**; the average weekly wage was **$1,478**.

On the date of accident, Petitioner was **49** years of age, single with **0** dependent child.

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

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

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

ORDER

The Arbitrator finds that Petitioner has failed to prove that she sustained an accident on June 5, 2014 that arose out of and in the course of her employment.

The Arbitrator finds that Petitioner has failed to prove that she timely notified Respondent of her June 5, 2014.

Lastly, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her injury.

Based on the aforementioned, the Arbitrator awards no benefits.

Please see attached Proposed Finding.

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

11-22-19
Date

NOV 25 2019

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARIA BUTLER,	)	**Case No.** **14 WC 33944**
	)	**15 WC 06417**
Petitioner,	)	
	)	Chicago, Illinois
v.	)	
	)	
STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF TRANSPORTATION,	)	
	)	
Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

An Application for Adjustment of Claim was filed by Petitioner, Marie Butler, seeking relief under the Illinois Workers' Compensation Act from Respondent, Illinois Department of Transportation (hereinafter, "IDOT"). Arbitrator Kurt Carlson held a hearing on May 7, 2019 and proofs were closed on September 9, 2019 in Chicago, Illinois. Petitioner was represented by Seidman, Margulis, and Fairman, LLP and Respondent was represented by the Illinois Attorney General's Office.

FINDINGS OF FACT

Petitioner's Testimony

Petitioner had been employed as a technical manager for six years and ten months. R. at 10-11. Within that position, Petitioner's role assisted Bureau Chief Jim Sterr analyze workers' compensation claims for IDOT's District 1. R. at 11.

June 5, 2014 Incident

On June 5, 2014, Petitioner lifted a box she thought contained office supplies, but rather contained files. R. at 12. This file box weighed between 20 to 30 pounds. *Id.* As a result, Petitioner felt a pull in her lower back. *Id.* After this occurred, Petitioner notified Chief Sterr via telephone. R. at 13.

September 24, 2014 Incident

On September 24, 2014, Petitioner had a meeting with her attorney and IDOT related to her EEOC claim. R. at 76. Petitioner walked her attorney out to his car. *Id.* When she was returning to the building and approximately 20 feet from the door of District 1, she stumbled on broken concrete. R. at 17. In an attempt to not fall and expose herself due to her dress, Petitioner twisted her back "like a pretzel." R. at 16. Petitioner did not fall to the ground. R. at 42. After this incident, Petitioner noticed her shoes were ripped, she composed herself in the bathroom, and called Chief Sterr. R. at 18.

Petitioner's Termination

On August 22, 2014, Petitioner was notified that she was being laid off on September 30, 2014. R. at 60-61. On September 30, 2014, Petitioner was laid off. R. at 20. While Petitioner acknowledges that 58 other staff assistants were also laid off at the same time, Petitioner testified that she was terminated as retaliation because she had workers' compensation claims. R. at 64. Petitioner filed her workers' compensation claims on October 6, 2014 and February 26, 2015.

Medical Treatment

The first medical record Petitioner claims is related to the accident is a physical therapy record from June 12, 2014. Px 4. This record does not mention Petitioner's June 5, 2014

accident. *Id.* On June 27, 2014, Petitioner told her physical therapist at Advocate South Suburban that her pain was related to her commute. *Id.* On July 1, 2014, Petitioner attended physical therapy and reported that she had a recent flair up again due to her commute. *Id.* On August 27, 2014, Petitioner was discharged from physical therapy due to lack of attendance. *Id.* None of these physical therapy records mention Petitioner injuring herself while lifting a box or a June 5, 2014 date of injury. *Id.*

On September 24, 2014, Petitioner went to Advocate Medical Group ("AMG") where she stated that she was walking back in from work when her left foot caught the open sidewalk. Px 2 at 7. Petitioner hurt her left ankle and back. *Id.* Petitioner characterized her pain as radiating from the lower region of her spine to the top of her head. *Id.* A cervical spine x-ray showed no fracture or acute bony pathology, but was suspicious of muscle spasm. *Id.* at 5. Petitioner's lumbar x-ray was normal. *Id.* at 6. Petitioner was diagnosed with muscle spasms of the neck and back pain. *Id.* at 9.

On September 26, 2014, Petitioner reported to her physician that she had radiating lower back pain that started gradually. Px 1 at 77. Dr. Imlach diagnosed Petitioner with lumbar spondylosis and lumbar radiculopathy. *Id.* at 79. He prescribed pain mediation, muscle relaxers, and a lumbar MRI. *Id.* Dr. Imlach's records do not show that Petitioner had tripped on the sidewalk. On October 9, 2014, Petitioner's lumbar MRI showed mild central canal stenosis at the L3-4 and L4-5 levels. Px 4.

On October 16, 2014, Dr. Imlach counseled Petitioner about her depressive symptoms and how these could be related to her back symptoms. Px 1 at 74. Petitioner was instructed to properly treat her depression. *Id.* On November 25, 2014, Petitioner followed up with Dr.

Imlach about her back pain. *Id.* at 62. Petitioner told Dr. Imlach that she was taking her prescription medication inconsistently. *Id.*

On April 14, 2015, Petitioner saw Dr. Imlach for her thyroid problem and her carpal tunnel syndrome. *Id.* at 59. She briefly mentioned back pain. *Id.* On April 25, 2015, Petitioner returned to receive medication refills and an injection for her left wrist. *Id.* at 52. On April 28, 2015, Petitioner underwent an EMG study that was negative. Px 4.

On August 11, 2015, Petitioner complained of back pain to Dr. Imlach and stated that this pain had been ongoing since her 2009 car collision. Px 1 at 47. Petitioner alleged her symptoms worsened in May 2014 when she was transferred to a different work site and in September 2014 when she fell. *Id.* In this patient history, Petitioner does not mention a back injury from lifting a heavy box in a storage room. *Id.* Dr. Imlach determined that her back pain was related to her depression and discontinuation of fluoxetine. *Id.* at 50.

Petitioner attended a physical therapy evaluation on June 5, 2015. Px 4. But, on July 20, 2015, Petitioner was discharged. *Id.* On September 8, 2015, Petitioner attended physical therapy at Advocate South Suburban. *Id.* Petitioner reported being in two major car collisions, one in 1996 and one in 2009. *Id.* On November 6, 2015, Petitioner was discharged again from physical therapy due to poor attendance. *Id.* She only attended two physical therapy sessions. *Id.*

On March 1, 2016, Petitioner told Dr. Imlach that her back flared up and that she felt sad, cried frequently, and had lost of interest in social activities. Px 1 at 43. Dr. Imlach found Petitioner had chronic back pain and depression. *Id.* at 46.

On June 21, 2016, Petitioner presented to the emergency room at Advocate South Suburban with a complaint of low back pain that radiated down into her right buttock and right hip. Px 4. Petitioner stated that she woke up at approximately 3 a.m. with this pain. *Id.* The ER

physician diagnosed her with low back pain with right-sided sciatica. *Id.* Petitioner's x-ray demonstrated a levoconvex curvature with lumbar spondylosis. *Id.*

On June 22, 2016, Petitioner presented to Dr. Imlach. Px 1 at 39. She woke up with a new onset of sharp pain in her lower back. *Id.* Petitioner described this pain as radiating down the sides of her legs into her feet. *Id.* Petitioner believed this pain was different than before since it was in her joints. *Id.*

On July 6, 2016, Dr. Imlach reviewed Petitioner's x-rays, which showed a narrowing of the spinal canal at L4, L5, and S1. *Id.* at 34. Petitioner described her pain as an "electric shock" and "burning." *Id.* Petitioner was told to undergo a repeat MRI and to see a neurosurgeon. *Id.* at 37. Petitioner did not follow up with this treatment.

On January 12, 2017, Petitioner returned to Dr. Imlach and reported that she had been in a second motor vehicle collision on December 16, 2016. Px 1 at 29. Since that accident, Petitioner had pain in her neck that radiated into her shoulders and arms. *Id.* Petitioner also had increased pain in her lower back that extended into her legs. *Id.* Dr. Imlach diagnosed Petitioner with cervical and lumbar strains and ordered MRIs of Petitioner's lumbar and cervical spine. *Id.* at 33.

Petitioner's lumbar MRI from January 24, 2017 showed mild degenerative changes and slight left neural foramina narrowing at L4-L5. *Id.* at 19. Overall, there was no significant change from her prior MRI. *Id.* Likewise, Petitioner's cervical MRI from the same date showed degenerative changes. *Id.* at 22. Petitioner's CT Scan of her brain was normal. *Id.* at 23.

On February 2, 2017, Petitioner reported to Dr. Imlach that her radicular symptoms were nearly resolved, but she now had generalized back pain. Px 1 at 13. Dr. Imlach cleared

Petitioner to drive, but deferred further treatment decisions to Dr. Chavez, Petitioner's neurosurgeon who treated her in 2008. *Id.*

On February 22, 2017, Petitioner followed up with Dr. Imlach after a neurosurgical evaluation with Dr. Chavez. *Id.* at 6. Dr. Chavez had found that Petitioner's symptoms were from soft tissue injuries and that surgical intervention was not needed. *Id.* Dr. Imlach diagnosed Petitioner with lumbar and cervical strains. *Id.* at 8. He recommended Petitioner begin physical therapy. *Id.*

On March 7, 2017, Petitioner attended physical therapy at Advocate South Suburban where she reported that she was involved in a car collision on December 16, 2016. Px 4. Physical Therapist Melissa Naegele found that Petitioner's reported and observable symptoms did not correlate with her referring diagnosis. *Id.* As such, Petitioner was discharged from physical therapy. *Id.*

On October 17, 2017, Petitioner went to an outpatient pain clinic at Advocate South Suburban. *Id.* Petitioner told Dr. Gastevski that while she was lifting heavy files at work she noticed a gradual extension of her low back and neck pain. *Id.* Dr. Gastevski diagnosed Petitioner with myofascial cervical, thoracic, and lumbar pain as well as asymptomatic minor foraminal narrowing in the cervical and lumbar spine. *Id.* He pointed out that Petitioner does not have a significant disk bulge or facet issue that could be causing her problem. *Id.* Dr. Gastevski opined that the majority of Petitioner's symptoms were caused by muscle pain and her overall level of inactivity. *Id.*

Nature and Extent

Prior to her June 5, 2014 injury, Petitioner had a preexisting lower back pain resulting from a motor vehicle collision that occurred in 2009. R. at 14. On April 2, 2009, Petitioner was

traveling at 50 miles per hour when she crashed in a concrete median wall. R. at 29. Petitioner's airbags deployed and Petitioner went to the hospital. R. at 30. Petitioner received facet injections in 2009 and 2010 for her back injury caused by this car collision. R. at 14. Petitioner admitted she was still receiving treatment for her back injury up until the June 2014 workplace injury. R. at 31. Additionally, Petitioner treated with Dr. Imlach at Advocate Medical Group for her back pain up until June 2014. *Id.* Petitioner testified that her back pain was worse after her June 2014 accident. R. 14-15.

On June 2, 2014, Petitioner's back pain was so severe that she requested an ADA accommodation to switch work locations from Schaumberg to Chicago because her commute was allegedly aggravating her back pain. R. at 31-32.

On December 16, 2016, Petitioner was involved in another motor vehicle collision while working as a Lyft driver. R. at 64. Petitioner was traveling on the Kennedy Expressway at approximately 40 miles per hour when she was rear-ended by another vehicle traveling approximately 60 miles per hour. R. at 65. As a result of this accident, Petitioner injured her back and neck and the pain extended into her legs. R. at 65-66. Petitioner was still experiencing lower back pain prior to her December 2016 car accident. R. at 26.

Currently, Petitioner has difficulty standing up and sitting down for extended periods of time. R. at 27. She has prescriptions for cyclobenzaprine, tramadol, and lidocaine patches. R. at 27.

Testimony of Bureau Chief James Sterr

James Sterr testified that he has worked for IDOT for 44 years. R. at 80. He has been the Bureau Chief of Claims for 20 years. R. at 78. As part of his job duties, Chief Sterr handles a

broad range of issues for IDOT including mechanic's liens, litigation defense, contract disputes, and workers' compensation matters. R. at 79.

In April 2014, Petitioner starting working for Chief Sterr's department as a staff assistant, but Chief Sterr was hoping to create a workers' compensation risk manager position for Petitioner. R. at 80. Chief Sterr testified that Petitioner received training from District 1, from his office, and from Tristar. R. at 81. Petitioner job was to investigate workers' compensation claims. R. at 82. Petitioner's job duties consisted of ensuring that accident reports, witness statements, and supervisory statements were completed. *Id.* She was instructed to make sure that IDOT had whatever it needed to allow employees to proceed with their claims or, conversely, investigate suspect claims. *Id.* In order to investigate claims, Petitioner was instructed to secure photographs, video footage, and witness statements. R. at 83. Chief Sterr was Petitioner's supervisor from April 14, 2014 until September 30, 2014. *Id.*

Chief Sterr testified that Petitioner was laid off on September 30, 2014 along with about 57 other staff assistants. R. at 58. Three staff assistants, including Petitioner, were not in the collective bargaining unit so they were terminated. R. at 86. 55 of the staff assistants were in the collective bargaining unit. *Id.* Approximately 30 of those staff assistants were eventually laid off as well. *Id.* These layoffs were due to an Office of the Inspector General Report that found IDOT was hiring individuals into staff assistant positions without interviews, job descriptions, or Central Management Service approval for allegedly political or policy-making (*Rutan* exempt) jobs when the actual positions were apolitical (*Rutan* covered). *See* Rx 5 and 6. Chief Sterr testified that Petitioner was not laid off because of her workers' compensation claim. R. at 91.

On September 25, 2014, Chief Sterr received an email from Petitioner that she had tripped the day before and that she was leaving work because she was sore. Rx 1. Once he

received this email, Chief Sterr ensured that the workers' compensation process was started and that Petitioner had the proper paperwork. R. at 93. In addition, Chief Sterr investigated as to whether there were cameras in the vicinity of Petitioner's fall. *Id.* However, the security camera for the main entrance was broken. R. at 95-96. Petitioner was aware that the camera for the front of the building was nonoperational and had previously made Chief Sterr aware of that fact weeks before the accident. R. at 96.

With regards to Petitioner's alleged June 5, 2014, Chief Sterr was never notified by Petitioner that she incurred a workplace injury. R. at 97. Petitioner never called or emailed Chief Sterr regarding her June 5, 2014 accident. R. at 97-99. Chief Sterr was not notified by Petitioner that she injured herself when she picked up a box in a supply room. R. at 98. Moreover, lifting boxes is not part of Petitioner's job duties. *Id.* The first time Chief Sterr was notified that Petitioner was potentially injured at work on June 5, 2014 was by the Attorney General's Office, who requested information about the claim; however, no IDOT file existed because the injury had not been reported. *Id.*

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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, 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. *Baggett v. Industrial Com'n*, 201 Ill. 2d 187, 194, 775 N.E.2d 908, 912 (2002). There are three general types of risks to which an employee may be exposed:

1) risks that are distinctly associated with the employment, 2) risks that are personal to the employee, and 3) neutral risks that do not have any particular employment or personal characteristic. *Potenzo v. Ill. Workers' Comp. Comm'n*, 378 Ill. App. 3d 113, 881 N.E.2d 523 (1st Dist. 2007). However, an injury is only accidental within the meaning of the Workers' Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Elayyan v. Indep. Mech. Indus, Inc.*, No. 09-WC-37192 (Dec. 10, 2014) (citing *Riteway Plumbing v. Indus. Comm'n*, 67 Ill. 2d 404, 367 N.E.2d 1294 (1977)); *Matthiessen & Hegeler Zinc Co. v. Indus. Bd.*, 284 Ill. 378, 383, 120 N.E. 249, 251 (1918).

June 5, 2014 Incident

The Arbitrator finds that Petitioner's June 5, 2014 injury did not occur. Petitioner testified that she injured her back when she picked up a heavy box in the storage room. The Arbitrator notes that Petitioner never told her any medical providers that she had injured her back picking up boxes until October 17, 2017, more than three years later. Petitioner never told Respondent about this accident, but rather Respondent only learned about this claim after it was filed with the Commission (*See* Section F for a detailed notice analysis). Chief Sterr testified that he had no idea why Petitioner would be lifting a heavy box since it was not in her job duties.

All of Petitioner's physical therapy records around the alleged June 5, 2014 accident point to Petitioner's commute as the source of her back pain. According to the Notice of Dismissal, a Primary Care Note from June 6, 2014 states that Petitioner continued to experience severe pain in her neck and upper shoulders, and was currently suffering from muscle spasms related to her daily commute. Rx 6. This is corroborated by the fact that Petitioner had requested to work out of the Thompson Center part of the week as an accommodation due to her

"back disability" just three days prior to her workplace accident. It should be noted that Respondent attempted to accommodate Petitioner's request for an ergonomic chair; however, Petitioner failed to follow up and specify which chair her doctor had recommended. Rx 7. The evidence only supports the conclusion that Petitioner had ongoing back pain from a prior motor vehicle collision that was aggravated by her commute. It was not until longer after Petitioner was let go that she first mentions a new date and mechanism of injury.

Accordingly, the Arbitrator finds that Petitioner's June 5, 2014 accident did not arise out of or in the course of her employment.

September 24, 2014 Incident

The Arbitrator finds that Petitioner's September 24, 2014 accident did not arise out of or in the course of Petitioner's employment. At the time of the accident, Petitioner was walking back into the office after walking her attorney to his car. Petitioner and her attorney had just met with IDOT due to Petitioner's EEOC allegations. The issue of whether an employee's injury arises out their employment as a result of work-related litigation is similar to cases that pertain to union activities. In those cases, the Illinois Supreme Court has found that Petitioner's must show that the union activity benefits the employer. *Schultheis v. Indus. Com'n*, 96 Ill. 2d 340, 348, 449 N.E.2d 1341, 1345 (1983). In this case, although Petitioner was clocked in and on the premises, Petitioner's injury did not arise out of her employment as actively pursuing litigation against one's employer is not in furtherance of one's employment. Conversely, Petitioner's EEOC discrimination claim engaged Respondent in an adversarial process at which both sides operated at arm's length as evident by the presence of Petitioner's attorney. Respondent did not benefit being required to defend itself from the Petitioner's accusations of discrimination.

In addition, Petitioner's lack of credibility calls into question whether this accident occurred. Recognizing that Petitioner has already filed a claim for an accident that did not occur and was not reported, Petitioner's claim stemming from her September 24, 2014 accident is questionable as well. It is highly suspect that Petitioner's injury occurred six days before she knew she was going to be laid off and occurred in an area where she knew the surveillance cameras were disabled. Petitioner testified that she called Chief Sterr after this accident occurred even though the email she sent the next day makes no mention of this phone call. Chief Sterr also denied that Petitioner ever made this phone call. Despite Petitioner's training in investigating workers' compensation, she failed to take any pictures of the alleged defect. All of these details together lead the Arbitrator to conclude Petitioner's testimony is not credible.

Petitioner actively worked against the advice of her own medical providers. Dr. Imlach noted that she did not take her medication as prescribed. Petitioner was also discharged from physical therapy on three separate occasions for noncompliance and one time because her objective symptoms did not match her subjective complaints.

Petitioner is a disgruntled ex-employee. She has filed claims against IDOT at the EEOC and Illinois Department of Human Rights. Petitioner's Employee Leave Balance Report (Rx 4) shows that Petitioner barely reported for work. She consistently and frequently missed work for hours and days at a time under various excuses. At hearing, she alleged that Respondent discharged her in retaliation for filing workers' compensation claims. This is impossible: Petitioner never even reported her June 5, 2014 accident and she was told prior to her alleged September 24, 2014 accident that she would be laid off. In contrast, Respondent presented ample evidence that Petitioner's employment was terminated based on the OEIG investigation

and report. Even Petitioner acknowledged that she was not the only staff assistant terminated. As Chief Sterr testified, many of those staff assistants were terminated as well.

Based on the aforementioned, the Arbitrator finds that Petitioner's accident did not arise out of or in the course of her employment.

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

Pursuant to the Illinois Workers' Compensation Act, "notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. 820 ILCS 305/6c (2012). As set forth in *Ristow*, "Section 6(c) explicitly provides that no proceeding can be maintained unless the employer has been given notice of accident within the statutory period. *Ristow v. Indus. Comm'n*, 39 Ill. 2d 410, 414, 235 N.E.2d 617 (1968). As in other statutes of limitation there is a *conclusive presumption* that the employer has been prejudiced by the failure to notify." *Id.* (emphasis added).

June 5, 2014 Incident

The Arbitrator finds that Petitioner did not notify Responder regarding her June 5, 2014 accident and that Respondent was prejudiced. While Petitioner testified that she called her supervisor, Chief Sterr, on the date of the accident, Petitioner never filed out a notice of injury form. She could not remember if she called the 1-800 number to report her injury, as all State employees are instructed to do, and could not remember if she sent an email to Chief Sterr. Chief Sterr, testified that he never received a phone call or email from Petitioner regarding this injury. Instead the first time Chief Sterr learned about this accident was months after it occurred from the Attorney General's Office.

Petitioner is well versed in workers' compensation claim handling and the reporting requirements. Unlike the typical employee, Petitioner worked as a risk manager or liaison

between Tristar and IDOT for workers' compensation claims. Petitioner's job duties consisted of monitoring and investigating workers' compensation claims. She knew what documents, including Illinois Form 45s and Employee Notice of Injury forms, were needed when a State employee reported an injury. Petitioner knew State employees were supposed to call the 1-800 number to report their injuries. In fact, Petitioner personally handled these documents in order to investigate and analyze workers' compensation claims in District 1. Petitioner knew that injured employees are required to report their injuries within 45 days.

Had Petitioner reported her injury in a timely matter, Chief Sterr would have taken the same steps he did when Petitioner filed her September 24, 2014 injury. Once Petitioner had sent Chief Sterr an email on September 25, 2014, Chief Sterr called District 1, made sure the proper paperwork was filed out, and investigated Petitioner's claim. None of this was done for Petitioner's June 5, 2014 accident. In fact, Chief Sterr stated that his office did not have a file for this claim when the Attorney General's Office requested information on it.

Because Petitioner never notified Respondent of her June 5, 2014 injury, Respondent was prejudiced. Respondent was unable to investigate Petitioner's claim. Chief Sterr was unable to talk to potential witnesses, look for video footage, or take any other additional investigative steps. Accordingly, the Arbitrator finds that Petitioner did not provide timely notice for her workplace injury that allegedly occurred on June 5, 2014.

September 24, 2014 Incident

The Arbitrator finds that Petitioner presented sufficient, credible evidence that she provided notice for her September 24, 2014 injury based on the testimony of Petitioner, Chief Sterr's testimony, Petitioner's email to Chief Sterr, and the Employee Notice of Injury form.

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

The Arbitrator finds that Petitioner condition is not causally connected to her workplace injury.

June 5, 2014 Incident

The Arbitrator finds that no medical evidence supports that Petitioner's alleged June 5, 2014 accident caused, aggravated, or accelerated Petitioner's preexisting back disability. While Petitioner testified that her back pain was worse after this alleged incident, the physical therapy records in closest temporal proximity do not mention that Petitioner suffered back pain because she lifted a heavy box. Instead, these records reflect that Petitioner's lengthy commute was the source of her increased back pain. There is no mention of Petitioner's June 5, 2014 incident in any medical records until 2017. Accordingly, the Arbitrator gives the medical records a greater weight than Petitioner's testimony.

September 24, 2014 Incident

The Arbitrator finds that no medical evidence supports that Petitioner's September 24, 2014 accident caused, aggravated, or accelerated Petitioner's preexisting back disability. Petitioner did report back pain the date of the accident; however, Dr. Imlach related Petitioner's back pain to her depression. Petitioner was already seeing Dr. Imlach for her preexisting back condition. Moreover, Petitioner's course of treatment did not change after this alleged accident occurred.

Petitioner's current condition is not causally related to her alleged workplace accidents. Petitioner suffered an independent intervening accident after September 24, 2014 to the same body part. On December 16, 2016, Petitioner was rear-ended in a motor vehicle accident while working as a Lyft driver. This case is very similar to *National Freight Industries* where a motor

vehicle accident was found to be an independent intervening cause since petitioner's symptoms worsened after the car accident. *Nat'l Freight Indus. v. Ill. Workers' Comp. Com'n*, 2013 IL App (5th) 120043WC, 993 N.E.2d 473, 483-84 (2013). But-for Petitioner's motor vehicle accident, Petitioner would not have sought treatment from a neurologist. Petitioner had not sought treatment for her alleged work accident since 2015. Instead, Petitioner had returned to work as a Lyft driver. Because of this motor vehicle accident, the Arbitrator finds that Petitioner's current condition is not causally connected.

K. What temporary benefits are in dispute?

The Arbitrator has already found Petitioner's accidents did not arise out of and in the course of her employment, Petitioner did not give timely notice of her June 5, 2014 accident, and Petitioner's current condition of ill-being is not causally related to the injury. Thus, no temporary benefits are awarded and the Arbitrator makes no finding in regard to the temporary benefits.

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

The Arbitrator has already found Petitioner's accident did not arise out of and in the course of her employment, Petitioner did not give timely notice of her June 5, 2014 accident, and Petitioner's current condition of ill-being is not causally related to the injury. Thus, no benefits are awarded and the Arbitrator makes no finding in regard to the nature and extent of Petitioner's alleged injury.

N. Is Respondent due any credit?

The Arbitrator concludes that group insurance, for which the employer contributed payments, has paid a portion of the medical bills. The amount paid by group medical is to be determined; therefore, Respondent receives a credit for those payments and is ordered to hold

Petitioner harmless in the event the company health insurance seeks reimbursement for those expenses.

Therefore, this Arbitrator finds that Respondent is due a credit for all medical bills it has paid in addition to any amount paid through group insurance.

Kurt A. Carlson

November 22, 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC003829
Case Name	NUGENT, JAY v. MB LAND COMPANY D/B/A MISSOURI LAND COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0440
Number of Pages of Decision	20
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Tyler Berberich
Respondent Attorney	Drew Dierkes, Patrick McHugh

DATE FILED: 8/31/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jay Nugent,

Petitioner,

vs. No. 17 WC 3829

MB Land Co., d/b/a Missouri Land Co., and
IL State Treasurer as Ex-Officio Custodian
Of the IL Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of employer-employee relationship, benefit rates, causal connection, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 55-year-old cement finisher foreman, sustained injury to his left rotator cuff on January 4, 2017 when he pulled on his tool belt which had become snagged on scaffolding. On March 9, 2017 he underwent arthroscopic rotator cuff repair, a subacromial decompression with capsular release, and an open biceps tenodesis. Petitioner returned to work as a cement finisher foreman for a different company at the same rate of pay, on August 11, 2017.

The Arbitrator found that Petitioner proved the existence of an employer-employee relationship with Respondent, and that his current left shoulder condition of ill-being was causally related to his January 4, 2017 accident. The Arbitrator calculated Petitioner's average weekly wage to be $2,004.63, and awarded Petitioner: his reasonable and necessary medical expenses; 31

weeks of temporary total disability benefits (from January 6, 2017 through August 10, 2017) at a weekly rate of $1,336.42; and 100 weeks of permanent partial disability benefits (20% body as a whole) at a weekly rate of $775.18.

On the Request for Hearing sheet in this matter, in evidence as Arb. X #1, Petitioner alleged an average weekly wage of $1,750.00. The Appellate Court has held that the language of section 7030.40 [now, section 9030.40] indicates that the request for hearing is binding on the parties as to the claims made therein. *Walker v. Indus. Comm'n*, 345 Ill. App. 3d 1084 (4th Dist., 2004). Accordingly, the Commission modifies the Arbitration award by finding Petitioner's average weekly wage to be $1,750.00, the figure he claimed on the Request for Hearing sheet.

Based upon the average weekly wage of $1,750.00, the Commission also modifies Petitioner's temporary total disability rate, to be $1,166.67. However, the modification of Petitioner's average weekly wage to $1,750.00 does not necessitate a change to his permanent partial disability rate, which remains at the maximum weekly rate of $775.18.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 9, 2020, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's average weekly wage is modified to $1,750.00 per week, and his temporary total disability rate is modified to $1,166.67 per week.

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 $1,166.67 per week for 31 weeks, commencing January 6, 2017 through August 10, 2017, as provided in Section 8(b) 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 Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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.

August 31, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-7/1/21
068

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0440

NUGENT, JAY
Employee/Petitioner

Case# **17WC003829**

MB LAND COMPANY DBA MISSOURI LAND COMPANY AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 3/9/2020, 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 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0000 MB LAND COMPANY D/B/A
MISSOURI LAND COMPANY
4200 OZARK RD
FARMINGTON, MO 63640-7370

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

NHBJYNMSTATE OF ILLINOIS)
)SS.
COUNTY OF **Kankakee**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jay Nugent
Employee/Petitioner
v.
MB Land Company dba Missouri Land Company; MB Land Company; Missouri Land Company, and the Illinois State Treasurer as Ex-Officio Custodian of the Illinois Injured Workers' Benefit Fund.
Employer/Respondent

Case # **17** WC **3829**

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 **Kankakee**, on **November 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS
On **January 4, 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 $**2,004.63**; the average weekly wage was $**2,004.63**.

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

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

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

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

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

ORDER
Respondent shall pay reasonable and necessary medical services of $106,172.17, as provided in Sections 8(a) and 8.2 of the Act.

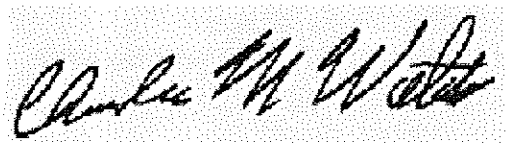
Respondent shall pay Petitioner temporary total disability benefits of $1,336.42/week for 31 weeks, commencing January 6, 2017 through August 10, 2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $775.18/week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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



Signature of Arbitrator

March 9, 2020
Date

MAR 9 - 2020

FINDINGS OF FACT

Procedural Issues

The petitioner, Jay Nugent, filed an Application for Adjustment of claim with the Illinois Workers' Compensation Commission on February 7, 2017 for injuries sustained on January 4, 2017. The petitioner's application has been amended numerous times and comes before the Arbitrator for hearing with the Third Amended Application entered into evidence as Petitioner's Exhibit 9.

The named respondents to this case include MB Land Company dba Missouri Land Company, MB Land Company and Missouri Land Company individually, and the Illinois State Treasurer as Ex-Officio Custodian of the Illinois Injured Workers' Benefit Fund.

Respondents MB Land Company and Missouri Land Company did not appear at arbitration. Petitioner's counsel detailed for the record that attempts had been made to serve each Respondent with notice of this hearing date. Evidence of those attempts at service is contained in Petitioner's Exhibit 8. Certified notice was sent to each of these parties.

Neither MB Land Company nor Missouri Land Company appeared at arbitration and neither were represented by counsel. Based upon the parties' failure to appear or to contact petitioner's counsel prior to hearing, despite reasonable attempts at notice being given, the Arbitrator determined that the hearing would move forward ex-parte.

In addition, petitioner's counsel entered into evidence subpoenaed documentation from the National Council on Compensation Insurance (NCCI), which contains a certification from a Proof of Coverage Analyst of NCCI Holdings, Inc. That certification details that the Illinois Workers' Compensation Commission has designated NCCI as its agent for the purpose of collecting proof of coverage information from Illinois employers which have purchased workers' compensation insurance. The certification further states that the analyst had performed a thorough search of the NCCI business records and database, which failed to reveal any filed policy information showing proof of workers' compensation insurance for any Respondent in this case on the dates of January 4, 2017. (PX 7).

STATEMENT OF FACTS

No evidence or testimony was presented by any party to dispute the facts testified to by the petitioner or the information contained in the treating medical records included within Petitioner's exhibits.

On January 4, 2017, Petitioner testified that he was employed as a cement finisher out of Cement Finisher's Local 11 by Respondent, Missouri Land Company.

Petitioner testified that he had only worked for Missouri Land Company for 4 days prior to January 4, 2017. During that time, his job duties each day were directed by Dave House, his supervisor from Missouri Land Company. His schedule was made by Missouri Land Company and the tools he used each day were provided by Missouri Land Company.

Petitioner also testified that he was paid by Missouri Land Company. Petitioner's Exhibit 11 contains a hand written pay check from Missouri Land Company, as well as two pay stubs. Petitioner testified that one of the pay stubs was from a payment directly from Missouri Land Company for one pay period and the other was a payment from the owner of the property on which he was working, because one of Missouri Land Company's checks bounced and the land owner paid all employees of Missouri Land Company for that pay period.

Petitioner explained that was scheduled to work 5 days per week, 8 to 10 hours per day for the pendency of the job for Missouri Land Company. Any overtime worked by Petitioner would be mandatory, as concrete finishers cannot simply walk away from drying concrete on a job site. Petitioner's pay stubs reflect, and Petitioner confirmed via his testimony, that he was paid a base hourly rate at the Local 11 Cement Finishers Union scale of $42.25 per hour. In addition, Petitioner testified that he was a foreman for Respondent and was therefore paid $1.50 per hour more.

On January 4, 2017, when Petitioner arrived at the work site, everything was wet and frozen from freezing rain the day and night before. Petitioner put on his tool belt that was also cold and stiff from the freezing rain. Petitioner explained that his tool belt contained materials such as nails, tools and a tape measure. He estimated that the bags on his tool belt extended approximately 6 inches out from the belt itself and also estimated that this belt could weigh up to 40 pounds with all of his tools and nails in it.

While walking to the work site, Petitioner testified that his tool belt got caught on scaffolding. When Petitioner attempted to pull the belt away from the scaffolding, he felt a pop in his left shoulder with immediate pain and an inability to raise his arm up.

Petitioner immediately informed his supervisor, Dave House, of his injury and tried to rest his arm for the next couple of days, thinking it may get better. However, due to consistent pain and loss of range of motion, Petitioner sought medical treatment.

On January 6, 2017, Petitioner was seen at Oak Orthopedics by Dr. Alexander Michalow. Dr. Michalow noted that Petitioner had been injured two days prior at work. Petitioner was reported to have been pulling a cord around his waist when he felt a sudden snap or pop in the left shoulder. He had been unable to lift his left arm well since the accident. It was further reported that while Petitioner had previous treatment for his right shoulder, he had no history of any injury or treatment to his left shoulder prior to this accident. Dr. Michalow diagnosed a full thickness rotator cuff tear and recommended that the Petitioner undergo an MRI and stay off work. (PX 2).

Petitioner did undergo an MRI of the left shoulder on January 24, 2017 and followed up with Dr. Michalow on January 25, 2017. At that time, Dr. Michalow reviewed the MRI results and diagnosed a full-thickness rotator cuff tear with some retraction and subacromial impingement. Dr. Michalow recommended surgical repair of the left shoulder. (PX 2).

On February 3, 2017, Petitioner sought out a second opinion on his left shoulder from Dr. Steven Chudik at Hinsdale Orthopedics. Dr. Chudik reviewed Petitioner's history of a work injury on January 4, 2017, noting, "while outside after it rained the day prior, he pulled his tool belt from right to left on his waist and hips, he felt a pop in the posterior aspect of his shoulder and pain." Dr. Chudik performed a physical examination and reviewed Petitioner's MRI, then diagnosed Petitioner with left shoulder suprapinatus tear retracted to mid humerus. (PX 1).

On March 9, 2017, Petitioner underwent left shoulder arthroscopic surgery performed by Dr. Chudik at Salt Creek Surgery Center. The procedure included 1) left shoulder arthroscopy; diagnostic of the glenohumeral joint and subacromial space, 2) left rotator cuff repair; massive suture anchor; arthroscopic modifier, 3) left subacromial decompression; coracoacromial arch sparing, 4) left capsular release (Associated with rotator cuff tear), 5) open left biceps tenodesis; subpectoral, and 6) left superior labral debridement. Petitioner's post-surgical diagnoses included 1) massive left rotator cuff tear, 2) left shoulder impingement syndrome, 3) left shoulder adhesive capsulitis, 4) left proximal biceps instability and partial rupture, and 6) left shoulder superior labral tear. (PX 1, PX 3, PX 5).

Petitioner underwent a course of post-surgical physical therapy at Riverside Medical Center from July 11, 2017 through May 26, 2017. (PX 4). During that time, Petitioner continued to follow up with Dr. Chudik and was kept on an off work status. (PX 1).

On June 16, 2017, Dr. Chudik cleared Petitioner to work with restrictions of no lifting greater than 10 pounds, and no reaching, lifting or repetitive overhead use of upper extremity. (PX 1). Dr. Chudik also indicates on this date that Petitioner had been taking some light duty jobs. However, at arbitration Petitioner testified that he did not do any light duty work until after he was cleared to do so by Dr. Chudik. In fact, Petitioner indicated that he did not return to work until August 11, 2017 when he got a light duty position with a company called PSI, who Petitioner indicated he regularly worked for prior to his short period of work with Respondent. Petitioner explained that during the month of May 2017 he may have stopped by some PSI job sites, but he never got paid for doing any work during that time.

Petitioner testified that Respondent in this case, Missouri Land Company, never offered a light duty position at any time.

On August 11, 2017, Petitioner was seen by Dr. Chudik who cleared him to return to work at light duty only. (PX 1). Petitioner testified that he did in fact go back to light duty work for PSI after this appointment.

On September 27, 2017, Petitioner followed up with Dr. Chudik who noted that Petitioner was doing well with his light duty return to work, but he reported soreness by the end of the day. Dr. Chudik recommended that Petitioner continue his home exercises. He also kept Petitioner on a light duty work restriction. (PX 1).

On November 8, 2017, Petitioner was placed at maximum medical improvement by Dr. Chudik and was given permanent light duty restrictions with relation to his left shoulder. (PX 1).

At arbitration, Petitioner testified that he continues to experience symptoms in the left shoulder. Petitioner gets sharp pain in the left shoulder when lifting certain weights. He also has loss of range of motion with that shoulder, remaining unable to lift his arm above shoulder height while extended to the front or side. Petitioner's left shoulder gets sore if he uses it too much, so he lets the other employees he supervises for PSI do the work. Petitioner takes Ibuprofen daily for his shoulder pain and unrelated hip pain.

Petitioner continued to work for PSI as a cement finisher foreman through the date of arbitration. Petitioner testified that this position allows him to work within his restrictions and pays the same union scale he made prior to his accident.

Prior to January 4, 2017, Petitioner had never sustained an injury to his left shoulder or sought medical treatment for that shoulder. Petitioner has also sustained no new injuries to his left shoulder since January 4, 2017.

CONCLUSIONS OF LAW

I. On the issue of whether respondent was operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, (A), the arbitrator hereby finds:

Section 3 of the Illinois Workers' Compensation Act states in relevant part, "The provisions of this Act hereinafter following shall apply automatically ... to all employers and all their employees, engaged in any department of the following enterprises or businesses which are declared to be extra hazardous, namely ... 1. [t]he erection, maintaining, removing, remolding, altering or demolishing of any structure 2. [c]onstruction, excavation or electrical work." 805 ILCS 305/3(1)and(2).

At arbitration, Petitioner testified that he was employed by Respondent, Missouri Land Company, as a cement finisher out of Local 11 cement finishers. At the time of his claimed January 4, 2017 accident, Petitioner was working on a parking lot paving job for Missouri Land Company.

The Arbitrator finds that there is no legitimate basis for dispute that work as a concrete finisher, paving and finishing a parking lot, falls within Section 3(2) of the Act as "construction work."

Based upon the type of work being performed by Missouri Land Company at the time of the petitioner's accident, the Arbitrator hereby finds that Missouri Land Company was operating under and subject to the Illinois Workers' Compensation Act, pursuant to Section 3(2) of the Act.

II. On the issue of whether an employee-employer relationship existed in this case, (B), the arbitrator hereby finds:

The Illinois Supreme Court has outlined a number of factors which weigh in determining whether an employee-employer relationship exists under the Illinois Workers' Compensation Act. Among these factors are the right to control the manner in which the work is done, the method of payment, the right to discharge, the skill required in the work to be done, and the furnishing of tools, materials or equipment. However, the most important of these factors in determining whether there is an employee-employer relationship is the employer's right to control the petitioner's work. *Bauer v. Industrial Commission*, 51 Ill.2d 169, 282 N.E.2d 448 (1972), *Yellow Cab Co. v. Industrial Commission*, 125 Ill.App.3d 644, 464 N.E. 2d 1079 (1st Dist. 1984), *Ware v. Industrial Commission*, 318 Ill.App.3d 1117, 743 N.E.2d 579 (1st Dist. 2000).

Petitioner testified that he had only worked for Missouri Land Company for 4 days prior to his accident. During that time, his job duties each day were directed by Dave House, his supervisor from Missouri Land Company. His schedule was made by Missouri Land Company and the tools he used each day were provided by Missouri Land Company.

Petitioner also testified that he was paid by Missouri Land Company. Petitioner's Exhibit 11 contains a hand written pay check from Missouri Land Company, as well as two pay stubs. Petitioner testified that one of the pay stubs was from a payment directly from Missouri Land Company for one pay period and the other was a

payment from the owner of the property on which he was working, because one of Missouri Land Company's checks had bounced and the land owner paid all employees of Missouri Land Company for that pay period.

It is clear from the evidence in this case, in addition to the undisputed and credible testimony of the Petitioner that Petitioner was employed by Missouri Land Company on January 4, 2017. Petitioner's work was controlled by Missouri Land Company, he used tools provided by Missouri Land Company and he was paid by Missouri Land Company.

Based on all evidence and testimony in the record, the Arbitrator finds that an employer – employee relationship did exist between Missouri Land Company and the Petitioner on January 4, 2017.

III. On the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, (C), the arbitrator hereby finds:

In order to be compensable the petitioner's injury must have arisen out of an in the course of the petitioner's employment by respondent. "The 'in the course of' element refers to the time, place and circumstances under which the accident occurred. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 44, 109 Ill. Dec. 166, 509 N.E.2d 1005 (1987). "Whether an employee's injuries 'arose out of' the employment may be determined under two different approaches. First, an injury arises out of the employment where its origin stems from a risk connected with, or incidental to, the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. 'A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties.' *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. Second, an injury arises out of the employment where it is caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment." *Dodson v. Industrial Comm'n*, 308 Ill.App.3d at 575-576.

On January 4, 2017, Petitioner testified that when he arrived at the work site, everything was wet and frozen from freezing rain the day and night before. Petitioner put on his tool belt that was also cold and stiff from the freezing rain. Petitioner explained that his tool belt contained materials such as nails, tools and a tape measure. He estimated that the bags on his tool belt extended approximately 6 inches out from the belt itself. Petitioner estimated that this belt could weigh up to 40 pounds with all of his tools and nails in it.

While walking to the work site, Petitioner testified that his tool belt got caught on scaffolding. When Petitioner attempted to pull the belt away from the scaffolding, he felt a pop in his left shoulder with immediate pain and an inability to raise his arm up.

At the time of this accident, Petitioner had arrived at work, put on his tool belt and was proceeding to the work site when his belt got caught on scaffolding. This accident clearly occurred in the course of Petitioner's employment by Respondent.

The Arbitrator also finds that the accident arose out of Petitioner's employment by Respondent. Petitioner was wearing a 40 pound tool belt that stuck 6 inches out from his body, which got caught on scaffolding on Respondent's job site. This risk is certainly connected with and incidental to Petitioner's employment.

Petitioner is at a greater risk than the general public of sustaining this type of injury, as the general public does not wear 40 pound, 6 inch wide belts that could get caught and require force to move, as was the case with Petitioner's accident.

Based upon the undisputed and credible testimony from Petitioner regarding his work accident, the arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of his employment by Missouri Land Company on January 4, 2017.

IV. On the issue of the date of accident, (D), the arbitrator hereby finds:

At arbitration, Petitioner credibly testified that he sustained a work related accident on January 4, 2017. Respondent has offered no evidence or testimony to dispute Petitioner's testimony.

In addition, when Petitioner first presented for medical care on January 6, 2017 with Dr. Alexander Michalow, he noted that Petitioner injured his shoulder two days prior, while at work. The remainder of medical records from Oak Orthopedics also reflect an accident date of January 4, 2017. (PX 2).

When Petitioner presented to Hinsdale Orthopedics on February 3, 2017, it was also noted that his left shoulder pain began on January 4, 2017.

A review of all of Petitioner's medical records reflects that he consistently reported to his providers that he sustained a left shoulder injury at work on January 4, 2017.

Based upon the Petitioner's credible and undisputed testimony, in conjunction with the corroborating medical records, the Arbitrator hereby finds that January 4, 2017 was Petitioner's date of accident.

V. On the issue of whether timely notice was provided to respondent, (E), the arbitrator hereby finds:

Following his January 4, 2017 accident, Petitioner testified that he informed Dave House, his supervisor from Missouri Land Company, in person of his accident and the injury to his left shoulder.

Respondent has offered no evidence or testimony to dispute the Petitioner's testimony regarding notice. The Arbitrator further finds that Petitioner's testimony regarding notice was credible.

Based upon the Petitioner's credible testimony and the lack of any contradictory evidence, the Arbitrator hereby finds that proper notice was provided to Respondent pursuant to Section 6(c) of the Act.

VI. On the issue of whether the petitioner's current condition of ill-being is causally related to his injury, (F), the arbitrator hereby finds:

After reviewing all evidence and testimony in this case, the Arbitrator has concluded that the current condition of ill-being in the Petitioner's left shoulder is causally related to his January 4, 2017 work accident.

The Petitioner credibly testified that prior to January 4, 2017, he had never sustained an injury to or had medical treatment for an injury to his left shoulder. He was working at a full duty capacity as of January 4, 2017.

Each of Petitioner's treating physicians note that Petitioner sustained an injury on January 4, 2017 while working for Respondent. Each of the accident histories note immediate pain and disability in the Petitioner's left shoulder following his January 4, 2017 work accident.

Petitioner began medical treatment on January 6, 2017 and was immediately diagnosed with a left shoulder rotator cuff tear, for which he eventually underwent surgical intervention and which led to his permanent physical restrictions.

No Respondent in this matter has offered any evidence or testimony to dispute the causal connection between Petitioner's January 4, 2017 work accident and his left shoulder condition.

Whether a causal connection exists between an accident and a condition of ill being may be determined from both medical and non-medical evidence. *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). A chain of events demonstrating a prior condition of good health, an accident and a subsequent disabling condition of ill-being will suffice to establish a causal connection between the accident and the employee's injury. *Westinghouse Elec. Co. v. Industrial Comm'n*, 64 Ill.2d 244, 356 N.E.2d 28 (1976); *Plano Foundry Co. v. Industrial Comm'n*, 356 Ill. 186, 190 N.E.2d 255 (1934); *Phillips v. Industrial Comm'n*, 187 Ill.App.3d 704, 543 N.E.2d 946 (1989).

In the case at bar, there is no dispute that Petitioner was in a state of good health prior to his January 4, 2017 accident and had a subsequent, disabling condition of ill-being thereafter.

Based upon all evidence and testimony in the record, the Arbitrator hereby find that the current condition of ill-being in the Petitioner's left shoulder is causally related to his January 4, 2017 work accident.

VII. On the issue of the petitioner's earnings, (G), the arbitrator hereby finds:

At arbitration, Petitioner testified that he had worked for Respondent for only four days at the time of his injury. Petitioner explained that was scheduled to work 5 days per week, 8 to 10 hours per day for the pendency of that job. Any overtime worked by Petitioner would be mandatory, as concrete finishers cannot simply walk away from drying concrete on a job site.

Petitioner's pay stubs reflect, and Petitioner confirmed via his testimony, that he was paid a base hourly rate at the Local 11 Cement Finishers Union scale of $42.25 per hour. In addition, Petitioner testified that he was a foreman for Respondent and was therefore paid $1.50 above scale. This increased pay for foreman is also reflected in Petitioner's pay records.

In reviewing Petitioner's Exhibit 11, the Arbitrator notes that the handwritten check from Missouri Land Company does not contain any data regarding what dates or hours of work it represents. Petitioner did not testify regarding what this handwritten check was for. Therefore, in considering the calculation of Petitioner's wages, the Arbitrator will use only the detailed pay records from Missouri Land Company.

The two pay records in Petitioner's Exhibit 11 indicate that he worked 40 regular hours and 3 overtime hours for Missouri Land Company. Given Petitioner's credible testimony that he was scheduled to work 8-10 hour per day, 5 days per week, this appears to represent the one week of work that Petitioner performed for Respondent.

The Arbitrator finds Petitioner's testimony concerning the mandatory nature of overtime work for cement masons to be credible. Therefore, this mandatory overtime will be included in Petitioner's average weekly wage.

In the one week worked for Respondent, Petitioner earned $2,004.63 in regular and overtime wages. Therefore, the Arbitrator finds that Petitioner's average weekly wage was $2,004.63.

VIII. On the issue of the petitioner's age at the time of accident, (H), the arbitrator hereby finds:

Petitioner's Exhibit 10 is a photocopy of what Petitioner testified to as his state issued driver's license. Petitioner confirmed that the information on that license is correct.

According to his driver's license, Petitioner date of birth is May 13, 1961. (PX 10). Therefore, as of January 4, 2017, Petitioner was 55 years old.

Based upon the undisputed evidence in the record, the Arbitrator finds that Petitioner was 55 years old at the time of his January 4, 2017 work accident.

IX. On the issue of the petitioner's marital status at the time of accident, (I), the arbitrator hereby finds:

At Arbitration, Petitioner testified that he was unmarried at the time of his January 4, 2017 work accident. Given the Petitioner's undisputed and credible testimony regarding his marital status, the Arbitrator finds that Petitioner was unmarried at the time of his January 4, 2017 work accident.

X. On the issue of unpaid medical bills, (J), the arbitrator hereby finds:

As detailed above, the Arbitrator has found that the Petitioner sustained an accident that arose out of and in the course of his employment by Respondent on January 4, 2017 and that the current condition of ill-being in his left shoulder is causally related to that accident.

Based upon the undisputed medical records and opinions of Petitioner's treating physicians contained therein, the Arbitrator further finds that all medical treatment reflected in those records has been reasonable, necessary and related to Petitioner's January 4, 2017 work accident.

Therefore, the Arbitrator orders Respondent to pay unpaid medical expenses in the amount of $106,172.17, as contained in Petitioner's Exhibit 13, pursuant to Sections 8(a) and 8.2 of the Act.

XI. On the issue of temporary total disability benefits, (K), the arbitrator hereby finds:

The records reflect that Petitioner was taken off work by Dr. Alexander Michalow due to his work related injury on January 6, 2017 and was kept an on off work status by Dr. Michalow again on January 25, 2017. (PX 2).

On February 3, 2017, Petitioner began treatment with Dr. Steven Chudik at Hinsdale Orthopedics. Dr. Chudik cleared Petitioner to return to work with restrictions including no left upper extremity use and no overhead lifting or reaching. (PX 1). Petitioner testified that Respondent did not offer any light duty work at that time.

On March 9, 2017, Petitioner underwent left shoulder surgery, performed by Dr. Chudik. Following surgery, Petitioner underwent an extensive course of physical therapy and was kept completely off work by Dr. Chudik through June 16, 2017. (PX 1).

On June 16, 2017, Petitioner was cleared by Dr. Chudik to perform light duty work, including no lifting greater than 10 pounds, no reaching, lifting or repetitive overhead use of upper extremity. (PX 1). No light duty work was offered by Respondent.

Petitioner remained on light duty, per Dr. Chudik, through his release from care on November 8, 2017.

On August 11, 2017, Petitioner testified that he returned to light duty work for another employer. He began working for a company called PSI, acting as a cement finisher foreman, making union scale wages.

On cross-examination, Petitioner was asked whether he did any work in May of 2017. Petitioner initially said he had, but clarified on re-direct examination that he was off work per Dr. Chudik in May of 2017 and he never did any light duty work until after he had been cleared by Dr. Chudik to do so. Petitioner testified that he may have stopped by PSI job sites while he was off work, but he never worked or got paid by PSI for doing so. After hearing the Petitioner testify in person, the Arbitrator finds his testimony regarding light duty work to be credible. The Petitioner became confused about dates on cross-examination, but clarified when he had and had not been working on re-direct examination when the dates were more clearly laid out for him.

Based upon the Petitioner's credible testimony regarding his medical treatment, restrictions, and period off work, in conjunction with a full review of all treatment records, the Arbitrator hereby finds that Petitioner was temporarily and totally disabled from January 6, 2017 through August 10, 2017.

Therefore, the Arbitrator order Respondent to pay temporary total disability benefits of $1,336.42 per week for 31 weeks, pursuant to Section 8(b) of the Act.

XII. On the issue of the nature and extent of petitioner's injury, (L), the arbitrator hereby finds:

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 record reveals that Petitioner was employed as a cement finisher at the time of the accident and that he was able to return to work as a cement finisher. However, the Arbitrator notes that the Petitioner has not returned to work as a cement finisher in the same capacity as prior to his accident. Petitioner was placed at MMI and released by Dr. Chudik on November 8, 2018 with permanent light duty restrictions related to his left shoulder. Although Petitioner has returned to work as a cement finisher foreman, he can no longer do the heavy lifting required by certain parts of the job, due to sharp pains in his left shoulder. Petitioner explained at arbitration that he had been a working foreman, doing the full duties of a cement mason at the time of his injury. Since his injury, Petitioner's shoulder gets sore and painful if he tries to help too much with the work that is going on, so he lets other employees under

him perform the tasks. Because of Petitioner's permanent light duty restrictions and inability to perform his work as a cement finisher in the same fashion he had prior to his work related injury, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident. Because Petitioner has over a decade of work prior to retirement age, during which time Petitioner will have to work with continued symptoms in his left shoulder and within the permanent physical restrictions placed by Dr. Chudik, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to work in a light duty capacity as a cement finisher foreman, making the same union scale wages he earned prior to his accident. Because of lack of loss of earning potential, the Arbitrator gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner was released by Dr. Chudik with permanent light duty restrictions related to his left shoulder on November 8, 2017. Petitioner's medical records consistently reflect a loss of strength in the left shoulder and symptoms of pain and soreness with activity. Petitioner also credibly testified that he experiences sharp pain in the left shoulder with certain lifts and that he has lost range of motion in the left shoulder. Petitioner can no long lifting his left arm, extended out to his side or in front of his body, above shoulder height. Because of Petitioner's ongoing disability, which is corroborated by the treating medical records, the Arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the body as a whole pursuant to §8(d)2 of the Act.